11-09227 С

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

hristopher Alves		- For State	State	of Maryland	•	artment of rtificate of			ıaı myç		eg. No.	201	1 4000
Physician	7	egistrar I. Decedent's Name (First, M	ddle,Last)					2	Date of Dea	th	Year	3. Time of Death 0903 hrs
Medical Examine		CHRIST			S	14	b City To	wn, or Location of		Month Decembe	r 8, 20	011 . County of Death	
, F		ia. Facility Name (if not instit 1392 Harford Squa					Edgew				F	larford	
Funeral Director		5. Social Security Number 9583 035-60- 1985	6. Se	x 7. Ago	e (In yrs. I	ast birthday) 21 Yrs.	If Under Months	1 Year If Under Days Hours		8. Date of Bio		90 Pir	thplace (State or PRHODE untry) ISLAND
any	-	Jsual Residence of Deceden 10a. State 10b. Cour			10c. City,	Town or Location	on						10d. Inside City Limits
B .11	_ _	MARYLAND	N/A					BALT	IMORE	Ε			1 X Yes 2 No
the Maryland or 28a-f show tified at once.		0e. Street and Number	-				10f. Zip 0			1	Ū	zen of What Cou	ntry?
eath with the Maryland items 23a or 28a-f sho		132 N. JA	NNEY	STREET 12. Was Decedent	Ever in U	S. 13. Was		21224 of Hispanic Orig	gin? (Spe	cify Yes or No		. S . A . 14. Race - Amer	ican Indian, Black,
→ <a <="" href="#" th=""><th>rune</th><td>1XX Never Married 2</td><td></td><td>Armed Forces? 1 Yes 2 If Yes, Give Year</td><td></td><td>lf Y∈</td><td>s, specify</td><td>Cuban, Mexican No specify:</td><td>, Puerto R</td><td>tican, etc.)</td><td></td><td>White, etc. Specify: BLAC</td><td>CK</td>	rune	1XX Never Married 2		Armed Forces? 1 Yes 2 If Yes, Give Year		lf Y∈	s, specify	Cuban, Mexican No specify:	, Puerto R	tican, etc.)		White, etc. Specify: BLAC	CK
nours af		15. Decedent's Education (16a. Decedent	's Usual O	ccupation (Give ing life. DO NOT	kind of wo	ork done	16b. I	Kind of Business/	Industry
36 vin 72 h	Сошріете	Elementary/Secondary (0- 9th grade	12)	College (1-4 or	5+)	LANDL	ORD				R	REAL ESTA	ATE
5-00 led with Hygiene other		17. Father's Name (First, Mid	dle, Last)	,				1		First, Middle,		Surname)	
	8 0	unknown 19a. Informant's Name/Relati	onship (T	vpe. Print)		19b. Mailing	Address			CE ALV		ity or Town, State	e, Zip Code)
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is max injury or other traumatic every	-	Cassandra Gr	•			1383	Harfo	rd Sq.	Dr.,	Edgewo	ood,	Md. 21	040
or Heal		20a. Method of Disposition 1 XX Burial 2 Crema	tion 3 [Removal from Sta	ate	Place of Disposi crematory or oth	er place)			Date			
Baltimore, permit. Pages I ar Department of Hec Important: If ite injury or other tr		4 Donation 5 Other 21. Signature of Eugeral Sep			МТ	CARME							MARYLAND ARFORD, P.A.
Derm Depa Impo		1014	9	alle		32	1 S.	PHILA.	BLVD	, ABER	DEEN	N, MD.,	21001
Physician VMedical	1	23a. Part I. Enter the disease failure. List only one ca	use on ea	ich line.			ne mode of	dying, such as o	cardiac or	respiratory ar	rest, sh	ock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final dise or condition resulting in deat		Multiple Gunsho			_						
	_	Sequentially list conditions,	b.	Due to (or as a cons	editence (AU.							
	⊆	if any, leading to immediate cause. Enter Underlying Cal (Disease or injury that initiate	use c.										
uted id ransit		events resulting in death) La	ıst d.	Due to (or as a cons									
te be executed ysician and burial - transit	edical	UNPENDED	x	AMENDED 5	per f	h g922	12-28	3–11 vt	:			<u> </u>	
8760 tificate Ing phys		F FEMALE: 3b. Was decedent pregnant past 12 months?	in the	23c. If yes, outcom	ne of preg		tal death	3 Ectopi	ic pregnan	ісу	23	3d. Date of deliver Month	ry Day Year
30x 6876 death certificate e attending phy for use as the	Physician/N		Unknown	4 Pregnant at	time of de	eath 5 Otl	ner (Speci	fy)					
P.O. B that the de ned by the		Part II. Other significant co	nditions	contributing to deat	h but not i	resulting in the u	nderlying o	cause given in P	art I.				the cause of death?
S, P. (uires tha n signed Id be det	pa Pa									1 Ye		No 3 Pro	utopsy findings available
cords,	Completed							·		auto perf	psy ormed?	prior to death?	completion of cause of
tal Rec		25. Was case referred to me	dical T					6.Place of Death	(Check o	1 ✓ Yes nly one)	21	No 1 🗸 Y	es 2 No
Vita hysician I directo	98 2	examiner? 1 ✓ Yes 2 No			ent 2	ER/Outpatient				Home 5		ence 6 🗸 Oth	er: Scene
n of ding Ph.h.		27. Manner of Death 1 Natural 5	ending	28a. Date of Inju FOUND:	ury 'ear)	28b. Time of I	njury 2	8c. Injury at World 1 Yes 2 ✓	_ [9	28d. Describe Subject sh		jury occurred	
r Attence r Attence ter death irector:	Certification:	2 Accident	nvestigati Could not	28e Place of Ir	njury - At h	0856 hrs nome, farm, stree	et, factory,	office building, e		or Town	State		tural Route Number, City
Division ospital or At hours after duneral Directly filled in by	5 5	4 Homicide	determine	d (Specify) Lo	_					392 Harford	Squa		rt, Edgewood, MD
	<u>ल</u>	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physic Examine	ian: To the best of m	y knowled mination	dge, death occur and/or investigat	red at the tion, in my	time, date and pl opinion, death o	lace, and o ccurred at	due to the cau the time, date	use(s) a e and p	ing manner as sta lace, and due to t	he cause(s)
To To con	¥	29b. Signature and title of ce	rtifier	and manner stated.			29c.	License number	r			. Date signed (M	
3 AV		(all o	e	HULL	dir			O.C.M.E.			De	cember 9, 20	л1
111		30. Name and address of pe Carol Allan, MD	rson who Assista	nt Medical Exa	miner	900 W. Bal	timore S	street, Baltim	ore, M	21223			
Sta	te	31. Date filed (Month, Day Y		32. Registra	ar Signal	barker							

OCME

∠xaminer To the Hospital or Attending Physician: The law requires that the dea h cerlificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the a lending physician and completed filled in by the funeral director, page 2 should be detached for use, as the burial-transit. Division of Vital Records, P.O. Box 68760

Funeral

Director

28a-f shov

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.

-¤bysician/

Medical

traumatic

Physician/Medical þ Completed B B ည ë Certificat

Medical

work?
1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🛣 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

only one)

M

31. Date filed (Month, Day, Year)

DEC

2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

1 5 2011

29c. License number R088852

29d, Date signed (Month, Day, Year) DECEMBER Z, JUII

KODNUSSN C. DIAMMA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith DUSNUE BULLE 31001, 21708

Cu

. Registrar's Signa

State Registrar

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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. amend #1 Per PHY G922 Charles Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40003 Certificate of Death Decedent's Name (First, Middle, Last) Abrams 2. Date of Death Muriel Irene Yea Physician/ Month 20:54 FISHMAN ABRAMS ZON Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A romit). 1410 MO566 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign ocial Security Number **Funeral** Days (Month, Day, Year) Months Hours Min Country) 053-36-7057 Director 1 M 2X F 08/17/1944 NY 67 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 X Yes 2 No BALTIMORE N/A MD ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21215 6014 HIGHGATE DRIVE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 0 **A** 1 Never Married 2 X Married 1 Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", Specify 3 Widowed 4 Divorced Completed WHITE other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) OWN HOME HOMEMAKER Be age 1 and 2 should be filed but of Health and Mental Hyt: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARRY FISHMAN LILLIAN GOLDBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR ABRAMS / HUSBAND 6014 HIGHGATE DRIVE, BALTIMORE, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date nent of Page 1 Department of Important: If it any injury or c 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) NEW MONTEFIORE CEM. 12/14/2011 PINELAWN, NY permit, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Due to (or as a consequence of): disease or condition resulting in death) Acute day Medical Examiner (Company Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): as the burial-transit Exam and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ 3 for in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Month Day Pregnant at time of death signed by the a Yes 2 Unknown 9 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available Endometrical conc Hospital or Attending Physician: The law n 24 hours after death.
 Funeral Director: After this certificate has b. prior to completion of cause of death?

1 Yes 2 No autopsy Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) the 31. Date filed (Month, Day, Year) 32 Registrar's Signati State Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\int\) 40004 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 1<u>0,</u> Physician/ Adamski 2011 Rosemarie 8:50a December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A1606 Charlotte Avenue Baltimore Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Min. 213-94-2061 **Director** 1 🗆 M 2 🕱 F 48 Yrs. 2-26-1963 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No N/A MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ian "natural", or items 23a or Medical Examiner must be Funeral 1606 Charlotte Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. 1 X Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry oe filed wn... ∽tal Hygiene. ∽er than "r (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A the Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F မ Leonard Adamski Mary Rozga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 1 and 2 s of Health a item 27 i Mary Adamski-Mother 1606 Charlotte Avenue Baltimore,MD 21224 altimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important: If it any injury or of once. cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 12-12-201 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Fun J. Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician rectal nets troic disease or condition concer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year signed by the at Id be detached for 1 ☐ Yes 2 ≝ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? I or Attending Physician: The after death.

Director: After this certificate by 1 Ves 2 No Yes 2 🛚 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) 2 🔀 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital within 24 hours a Medical 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Prantitioner: To the best of my knowledge, deeth contrad at the time date and place, and due to the bases(s) and mi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oh D40850 12-12-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9103 Franklin Square Dr. Baltimore.MD 21237 Yvorne Ottaviano, M.D. 31. Date filed (Month, Day, Year) State 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day ca1101 2 10:25 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 507 Delmar Ave Glen Burnie Anne Arundel Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Days 1 XXM 2 | F Country) Director 192-18-1659 90 1921 March 29. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits must be notified at Director 28a-f Anne Arundel Glen Burnie 1 Tes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 Delmar Ave 21061 USA ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married XX Yes Baltimore, Maryland 21215-0036 1 Yes XXX No Specify: If Yes, Give 3 Widowed 4 Divorced Specify Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manager US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Brailer Victoria Rickleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 216 Turnwood Ct, Glen Burnie, MD 21061 Jane Spillner Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Glen Haven Cemetery Dec 3, 2011 Glen Burnie, MD afure of Funeral Service Dicensee Name and Address of Facility
Fink Funeral Home, P.A. Gregory Fink M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Vecuns Due to (or as a consequence of resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 2 No 3 □ Probably 4 □ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 1 🗌 Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work? Funeral Director: / Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D38762 who completed cause of death (Item 23a) (Type, Print) Sharon State Registrar

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{ 5			For State	State of Maryland		rtment of F ificate of L		nd Mer		20	11 40006
	Physicia	n/	1. Decedent's Name (First, Middle, Last) BOXEV TOLLVE	r Brady	Cert	incate of L	<i>Death</i>		Date of Deat	Day	3. Time of Death
7	Medic Examin	al	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death							of Death	
Ý 🖥	<i>k</i>									9. Birthplace (State or Foreign	
4	Funeral Director	6	1110 00 1700	2 F S4	- Yrs.	Months Days	Hours	Min.	(Month, Day,		Country
	Maryland 28a-f show otified at	Director	10a. State 10b. County Da Him	10c. City, To	own or Loca		K				10d. Inside City Limits
Ser.	vith the M 23a or 26 st be not		10e. Street and Number 2020 Feather bed L			10f. Zip Code	207		1	0g. Citizen of W	
. (Sr.	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 MZ Yes 2 No If Yes, Give Year or Dates.	13. W	as Decedent of H Yes, specify Cuba	n, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race	- American Indian, s, White, etc.
21215-0036	ed within 72 hours Hygiene. other than "natur ent, the Medical E	Completed	15. Decedent's Educat (Specify only highest grade c	tion 1	(Give ki life. DO	ent's Usual Occup nd of work done of NOT use retired) SUDEN	during most o	of working		16b. Kind of Bus	siness/Industry
Maryland 2	ild be filed w Mental Hygi larked other atic event, f	To Be	17. Father's Name First, Middle, Last) John F. Brady			1	18. Mother	ra W	illiam		
	and 2 shoul Health and I tem 27 is ma	- 0	19a. Informant's Name/Relationship (Type, F Jessie Brady (WII	Print)	19b. Mailing 2020	Address (Street) Flather	and Number Ded L	or Rural Ro	oute Number, Apt. 2	City or Town, Sta LA GW	ate, Zip Code) 2126 T YNN CAL MD
Baltimore,	permit. Page 1 and Department of Hea mportant: If item any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	cem	eterv. crema	ition (Name of atory or other place TOWN	atory t	2 15			City or Town, State 7Dre MD
(Soo Baltimo	permit. Page Department Important: I any injury o once,		21. Signature of Funeral Service Licensee	y	22.	Name and Addres	ss of Facility	Vacua	nn C.E andal	treene:	Funeral Services MD 21133
	Physician/		23a. Part 1. Enter the disease, or complicat shock, or leart failure. List only one ca Immediate Cause (Frnal				g, suc h as c		spiratory arre	st,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	ce of):		Lung				UNKNOWN
م کے د	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):						wilmon
120	be executed sician and burial-transit	<u></u>	that initiated events c resulting in death) Last	Due to (or as a consequen							
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Вох	ith cer ittendii for use	Physician/Medic	in the past 12 months?	If yes, outcome of pregnancy 1 Live Birth 2 Fetal di 4 Pregnant at time of dea 9 Unknown	eath 3 🗌	Ectopic pregnand Other (specify)	sy		-	23d. Date Mon	e of delivery th Day Year
s, P.O.	ires that the des signed by the a Id be detached i		Part II. Other significant conditions contrib	outing to death but not resulti	ng in the un	derlying cause gi	ven in Part I.				bute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records,	ne law require e has been si age 2 should I	Completed by							24a. Was all autops perform	med? pi	/ere autopsy findings available rior to completion of cause of eath?
E B	zian; Th ertificat ector, pa	Be Co	25. Was case referred to medical examiner?				ace of Death	n (Check on	1 Yes ; ly one)	2 No 1	Yes 2 No
of Vii	Physic erthis ce eral dire	은	1 Yes 2 No	1 Inpatient 2 ER	Bb. Time of	28c. Injur	y at			ence 6 Other	
ision (pital or Attending Physician: The law ours after death. eral Director: After this certificate has filled in by the funeral director, page 2	Certificate:	Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day, Year) 28e. Place of Injury - At home	injury e, farm, stree		:? Yes 2 □ 1				r or Rural Route Number,
Divi	urs afte ral Dire			building, etc. (Specify)					City or Town		
	To the Hospital within 24 hours of To the Funeral Completely filled	Medical	(Check 2 Medical Examiner:	n: To the best of my knowled On the basis of examination ar actitioner: To the best of my l	nd/or investi	gation, in my opinie	on, death occ	curred at the	time, date an	d place, and due	to the cause(s) and manner stated
	Vith vith com	=	29b. Signature and title of certifier	ATTENDIN	ζ	29c. Licens	number	48		Pod. Date signed	(Month, Day, Year)
	5		30. Name and address of person who comp TANE TANS IND I 31. Date filed (Month, Day, Year) NEC 15 2011	leted cause of death (Item 23	Ba) (Type, Pr	int)	· E #	204 /	3 Action	ione n	12 2128
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	back	1		,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ A Michael P. Boettcher III December 2011 Medical acility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** TOOKINS TUS Dita 8 Date of Birth If Under 24 Hrs. Birthplace (State or Foreign
Country) Age (In yrs, last birthday) **Funeral** (Month, Day, Year)
Dec. 2, 2011 N/A Month Hours Director 1 **X**M 2 □ F MD Yrs Usual Residence of Decedent r 28a-f show notified at 10b. Count death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director VA United Norfolk 1 Ves 2X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n 23513 Funeral 3458 Chesapeake Blvd. USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iten | Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify White Specify: "natural" Completed 3 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+ N/A N/A the traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Michael Boettcher Jr. ဂ္ဂ Kara Traversie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael P. Boettcher Jr. permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra 3458 Chesapeake Blvd. Norfolk VA 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith 12/15/11 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ARREST Physician/ CARDIAC disease or condition resulting in death) Medical Due to (or as a consequence of): xaminer CONPUEX CONGENITAL TSUST H Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe this certificate has 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital Other: 2 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title D6956L

Registrar

State

Goo North Wolfestreet

person who completed cause of death (Item 23a) (Type, Print)

SACCO

MELISSA JEROONEK

31. Date filed (Month, Day, Year)

158

State Registrar 31. Date filed (Month, Day, Year)

OFC 1 5 2011

Aug. 32. Registrar's Signature

S. Santo

10 Julie

d cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2 Marker Place Dandale MD 21222

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM 2 per PHYS, G922, 12/15/2011, WS

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12/6/2011 Baden ace Physician/ Morte m/2 Pax 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Northwest Hospital 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** Months 217-24-5227 1 □ 📉 2 🗆 F **Director** 82 09 29 20 MD Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Baltimore 1 Yes 2 No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 3718 Patterson Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry
Baltimore City permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. 12th grade College (1-4 or 5+) 4yrs Public Schools Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Cornelia Lindsay Rozwell Baden 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3718 Patterson Ave, Baltimore, Md 21207 Delores Baden-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 12/12/2011 Baltimore, Maryland 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Funeral Service License 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph. sician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Physician/Medical eance the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Month Year signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available 24a. Was an cate has prior to completion of cause of death? 2 No certificate 1 Yes Yes 2 Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

Secumber 06, 2011 29b. Signature and title of certification Gramatikova, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 DED, COURT ROAD

AMELA GRAMATIKOVA RANDAIISTOWN, ND 21133 31. Date filed (Month, Day, Year) 32. Registra & Signat DEC 1 5 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Items 1,2 per dr., g922 22/11/5/2011 hbbt/ Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/12/2011 Dewayne Browne Month Physician/ 102 to AM W work Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD rentyon 52C Mesaco Health 8. Date of Birth Jan 10, 1937 9. Birthplace (State or Foreign Social Security Number Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Days 1x M 2 🗆 F Months Hours Washington DC 577-48-4409 74 Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City. Town or Location Director 1xxYes 2 No District of Columbia Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 5201 Connecticut Avenue NW #808 20008 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Ves 2 No If Yes, Give Year or Dates. ò 1X Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wash Hospital Center Nurse Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl Green Elliott Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1023 15th Street SE Washington DC 20003 Jeanette Wren/NIece 20b. Place of Disposition (Name of cemeter), crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition November 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 21,2011 Beltsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert G Mason Funeral Home Inc 21, Signature of Funeral Service Licens 1661 Good Hope Rd SE Washington DC 20020 Donald R Gray not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one sa ns that caused the deat use on each line. Immediate Cause (Final Due to or s a consequence of): Physician/ 5-124 te disease or condition resulting in death) Medical Examiner Cul ue to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events Due to (or as a consequence of): resulting in death) Last anding physician ause as the burial-Physician/Medical Records, P.O. Box 68760 for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ atten in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 Ures 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peroxysa 2 No 3 Probably 4 Onknown 1 Yes Completed Scuen Dysphagi 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy performed death? 1 Yes 2 No certificate 1 Yes 2 Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 \sum Yes 2 \sum No Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al completed filled in by the fu Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 Sician DB020174 (240)6021730 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ola Do-Audain HD 6858 inion Dr. HEL 32. Registrar's gnature 31. Date filed (Month, Day, Year) State 1 5 2011 Registrar

			Please Type of amen State	r Print in Black I d 20b, per fh, s of Mary 1110 (2023)	Indelible Ink. Ensure 1922 12-15-11 sm Bartment of Health and 1/06/2011 III Prificate of Death	All Copies A l Mental Hygien	re Legible. ne	
	_		State amend #41 & 20b&c Pe	er FH	ertificate of Death			
	Physicia Medi		Frances Chapn	7an		2. Date of Death Month	Day Year 2:45 A M	
	Exami	ner	4a. Facility Name (if not institution, give street and n Mawor Care — Dull	umber) Uney	4b. City, Town, or Location of Death	1	4c. County of Death Bultimore	
-	Funeral Director		5. Social Security Number 080 · 20 · 2202 Usual Residence of Decedent 6. Sex 1 □ M 2 ▼ F	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country) NC	
	laryland 3a-f show iffied at	ector	10a. State 10b. County MD Baltimore	10c. City, Town or L	ocation dallstown		10d. Inside City Limits 1 □ Yes 2 ☒ No	
	with the M 23a or 20 ust be not	Funeral Director	10e. Street and Number 3949 NeMo Road		10f. Zip Code 21133	10g. (Citizen of What Country?	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	è	Armed	Forces?. s 2 No aive	Was Decedent of Hispanic Origin? (Sy If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
21215-0036	J within 72 hou ygiene. her than "nati ht, the Medica	Be Completed	12th grade 4	(Give (1-4 or 5+)	edent's Usual Occupation & kind of work done during most of wor DO NOT use retired) WANCH MANAGER	king 16b. St De	Kind of Business/Industry ate of Maryland pt. of Social Service	
Maryland	uld be filed Mental Hy narked oth natic event	To B	17. Father's Named First, Middle, Last) George Parks		18. Mother's Nar	ne (First, Middle, Maide beth Dav	en Surname) √√,S	
	and 2 should Health and Me tem 27 is marl		19a. Informant ame/Relationship (Type, Print) Tevence C. Chapmar	1/500 1140	ing Address (Street and Number or Ru Elbank Avenue	3 Baltimo		
Baltimore,	Page 1 attent of he tant: If ite		20a. Method of Disposition 1 ★ Burial 2 ★ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State 20b. Place of Disp Greenmo Mt. Zion		7/11 13	attimore, Mb	
Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	2	2. Name and Address of Facility \(\) (8728 Liberty Roa		ene Funeral Sovices Istown MD 21133	
	hyvician/ Medical		23a. Part 1. Enter the disease, or complications that shock, or hear failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	t caused the death. Do not enteach line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death	
Macrael .	Examiner	ner	Sequentially list conditions, b.	erebral o (or as a consequence of):	Vascular	Accide	nt	
189	e executed cian and ourial-transit	Examiner	Cause (Disease or injury that initiated events c.	o (or as a consequence of):	& Breast C	Cancer	^	
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. Box 68	Attending Physician: The law requires that the death certificate be ar death. Fright of the artificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the but	Physician/Medical	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
s, P.O.	ires that t signed b Id be deta	þ	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?	
ecords,	The law require ate has been si page 2 should l	Completed				24a. Was an autopsy performed?		
a	iysician: The is certificate director, pag		25. Was case referred to medical		26. Place of Death (Chec	1 Yes 2 🛣	No 1 L Yes 2 DCNo	
Ĭ;	Physici this ceral direc	일	examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpatie	- Other	ome 5 🗀 Residence	6 Other (Specify)	
on of	ittending Pl death. stor: After th y the funera	Certificate:	1 Natural 5 ☐ Pending (Mo 2 ☐ Accident Investigation	e of injury nth, Day, Year) 28b. Time o injury	of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred	
	i girigi e		3 Suicide 6 Could not be 4 Homicide determined 28e. Place built	e of Injury - At home, farm, str ling, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check 2 Medical Examiner: On the base)	asis of examination and/or inves	occurred at the time, date and place, a stigation, in my opinion, death occurred a e, death occurred at the time, date and p	it the time, date and place	ce, and due to the cause(s) and manner stated.	
			29b. Signature and title of certifier	el Do	29c. License number HCO544	2 4 1 3	Date signed (Month, Day, Year) 2 — 2 —	
_	0		30. Name and address of person who completed car CYrus Asadi, I	ise of death (Item 23a) (Type, I	Print) Proft Way Lut	nerville,	MD 21093	
	Stat Registra	_	31. Date DECorts, 5,2011 Lenus	Registrary Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 14:29 Physician/ Pear Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MD Raltimore land Nedical Center If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 287-28-0688 **Director** 1**X**XM 2 □ F Ohio April 23,1928 83 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City. Town or Location Director 1 🖺 Yes 2 🗌 No Prince George Laurel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 501 Main St., #334 20707 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes Give Completed 3₹Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Self Storage Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Howard Carr Mary Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. Tull/Daughter 604 Carroll Avenue, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12/11/2011 4 Donation 5 Other (Specify) West Arundel Crem. Odenton, MD 22. Name and Address of FacilityDonaldson Funeral Home, P.A. Signature of Funeral Service Licensee Ken Skele M01053 313 Talbott Ave., Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) diverti autic **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Year Day Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \(\sum_{\text{Nursing Home}}\) 5 \(\sum_{\text{Residence}}\) 6 \(\sum_{\text{Other}}\) Other (Specify) ဂ္ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death I Director: A d in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Funeral Directory filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funer

completely file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 29b. Signature and title of certifier

DHMH 17 Bev 06-2011

State Registrar 30. Name and

31. Date filed (Month, Day,

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Christopher Cole		1- For State Registrar	of Marylan	•	artment of rtificate of		nd Menta	al Hygiene	Reg. No. 2 (011 4001		
Physicia Medical Exami		OHRIBIOTHER	COLE					2. Date of D Month Decemb	eath Day Year Der 5, 2011	3. Time of Death 0425 hrs		
		4a. Facility Name (if not institution, gi Laurel Regional Hospital	ve street and numb	per)		4b. City, Town, or Laurel	or Location of Death 4c. County of Death Prince George's					
Funeral Director			4VM 005				ar If Under	Min.	Birth(MM/DD/YYYY) 5/1987	(MM/DD/YYYY) 9. Birthplace (State or ForeignMARYLAND Country)		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	. Town or Locat	ion		12/2	3/1707	10d. Inside City Limits		
*	tor	MARYLAND N/A	Α			rimore				1 Yes 2 No		
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 6714 TOWNBROOM	ייס א סת צ	' ח		10f. Zip Code	01007		10g. Citizen of Wha	•		
th with the ems 23a	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Deced	ent Ever in U				? (Specify Yes or uerto Rican, etc.)	U.S.A No- 14. Race - White	- American Indian, Black,		
0036 within 72 hours after death with the Maryland piene. ret than "astural", ar items 23s or 28s-f she Medical Examiner must be notified at once	by Fur	3 Widowed 4 Divorce	1 Yes	2 XX No		Yes 2 XXNo		33.13.13.21.1, 313.7		Specify: BLACK		
2 hours		15. Decedent's Education (Specify of Elementary/Secondary (0-12)	only highest grade of College (1-4			t's Usual Occupa ost of working life			16b. Kind of Bus	iness/Industry		
21215-0036 Juld be filed within 72 hours Mental Hygiene. marked other than "natur c event, the Medical Exam	Completed	12th grade 17. Father's Name (First, Middle, Last			I	ISABLED			N/A			
21215-00 uld be filed wit Mental Hygien marked other c event, the Me	æ	STEVEN COLE	1)					Name (First, Middle $IN LITTL$)	e, Maiden Surname) F			
MD 21 d 2 should th and Me n 27 is ma numatic ev	၉	19a. Informant's Name/Relationship (** DeKeah Williams			(1)		et and Numbe	er or Rural Route N	umber, City or Town			
		20a. Method of Disposition 1 Burial 2 X Cremation 3			Place of Disposi crematory or oth	tion (Name of center place)	metery,	Date	20c. Location -	re, Md. 21207 City or Town, State		
Baltimore, vermit. Pages I ar Department of Hee impartment. If ite injury ar ather tr		4 Donation 5 Other Specify 21. Signature of the Specify	<u></u>		TRO CRE			12-17-20		MORE, MARYLAND		
		(Colle	alle		1 12	LOW M GO	KTH AV	ENUE, BAI	TIMORE, MI	L HOME P.A. D 21217		
Physician /Medical Examiner		23a. Part T. Enter the disease, or comp failure. List only one cause on e. Immediate Cause (Final disease a.	complications that caus ach line.							rt Approximate Interval Between Onset and Death		
		or condition resulting in death) Sequentially list conditions, b.	Due to (or as a cor	nsequence of	f):					9		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cor	nsequence of	f):							
scuted and transit		events resulting in death) Last	Due to (or as a cor	nsequence of	r):							
O, e be execut sician and burial - tra	edical	■ UNPENDED	AMENDED 23			g922 12 -	27–11	sm				
lox 6876 eath certificate attending phy for use as the b	١	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo		2 Fet	al death 3	Ectopic pr	regnancy	23d. Date of d Month	delivery Day Year		
Box 6 le death cer the attendi	Physici	1 Yes 2 No 9 Unknown	9 Unknown		3 Oth	er (Specify)						
i, P.O. ires that th signed by	<u> </u>	Part II. Other significant conditions	contributing to de	ath but not re	esulting in the u	nderlying cause g	jiven in Part I			oute to the cause of death? Probably 4 Unknown		
cords law requii	Completed								opsy pri	ere autopsy findings available for to completion of cause of		
Rec a: The litificate h or, page		25. Was case referred to medical				26 Plana	of Dooth (Ch			eath? Yes 2 No		
Vital hysician: this certif	ě	examiner? 1 ✓ Yes 2 No	lospital: 1 Inpa	tient 2	ER/Outpatient		Other -	ursing Home 5	Residence 6	Other:		
ion of tending P eath. ior: After the funera		27. Manner of Death 1 Natural 5 Pending	28a. Date of ir (Month, Day	njury (,Year)	28b. Time of In		y at Work? (es 2 No	1	how injury occurred	d .		
Divisi al nr Att s after de al Directe ed in by t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined determined (Specific) 2 Accident Investigation 2 28f. Location (Street and Number or Rural Route Number or Rural Route Number or Town, State)								or Rural Route Number, City		
Division of Vital Records, P.O. Box 68760, To the Hospital ar Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil and transil.	edical Ce	4 Homicide (Specify) 29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the within To the compl	Med	one) 2 Medical Examiner 29b Signature and title of certifier	and manner state	d 1	id/or investigation	29c. License		red at the time, dat		e to the cause(s) d (Month, Day, Year)		
		Vieter States	1/201	100	50	O.C.1	M.E.		December 1			
		30. Name and address of person who over the Victor Weedn MD JD As		- t 17	000 144	Baltimore S	treet, Balt	imore, MD 212	223			
Sta Registr	te ar	31. Da DECM 1"50 2017	32. Regist	rar's signatur	er 900 vv.							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Physician/ Contes 5 amol Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner on Secours Baltimore mure MD Balt More Ca Year If Under 24 Hrs. If Under 1 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**X**□ M 2 □ F Months Hours Min. 03 30 Year 68 Yrs. Director 212-42-4509 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? ь 10e. Street and Number items 23a or ner must be r Funeral 21223 U.S.A. 2210 Penrose Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status "natural", or iter edical Examiner Black, White, etc. δ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2√ No Specify: Specify: 3 Widowed 4 X Divorced Black Completed er than "natur, the Medical E 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12th grade College (1-4 or 5+) filed within al Hygiene. HABC Engineer permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Henry N. Coates Sr. Dorothy Truiett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2210 Penrose Ave. Baltimore, Md 21223 Dorothy Jones-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) King Memorial Park 12/14/2011 Woodlawn, Md Signature of Funeral Service Licenses M22-NampandrAddings of Facility cla ax 4300 Wabash Ave, 21215 Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 50 Physician/ PSIS disease or condition Medical resulting in death) Due to (# as a consequence of): Examiner MONIC Sequentially list conditions, Examiner if any, leading to immediate Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical book The law requires that the death certificate be d NO XI Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? į Month Day Year Pregnant at time of death the detached g 🗌 Unknown P.O. s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 performed? Yes 2 N this certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: ျ 1 🗌 Yes 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident the Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

2000 W. Baltimere St Baltimore, MD

and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registra s Signa

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5 2011

Date filed (Month, Day, Year)

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40016 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12/10/2011 Rosemary Cabral 11:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8 Date of Birth **Funeral** Min (Month, Day, Year) Hours 577-48-0946 **Director** 1 M 2 X F 76 03/19/1935 Washington, DC Usual Residence of Decedent or 28a-f show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arthrent of Health and Mental Hygiene.

ortant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho intry or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 X No Edgewater 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21037 USA 144 Washington Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secratary US Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Joseph Collins Josephine Bonoveirs 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Cabral Stogdale 3510 Evans Road, Huntingtown, MD 20639 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service Licens 22. Name and Address of Facility Advent Funeral Services Hudson Street, Ste. 110, Annapolis, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) **Examiner** Due to (or as a finsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Hospital or Attending Physician: The law requires that the death 24 hours after death. in the past 12 months?
1 Yes 2 No detached for Pregnant at time of death the 9 Unknown Unknown P.O. ò Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed? Yes 2 X No death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie CSPUCOU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 1 5 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G922 12/22/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Prince George's Landover 2210 Brightseat Rd. #302 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** (Month, Day, 08 Country) 1 M 2 XF Months Days Hours DC Director 579-58-6957 64 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 □ No Landover Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA #302 20785 2210 Brightseat Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Black Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Representative Lucent Technologies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Jimmy Lee Ingram James Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8022 High Oak Road, Glen Burnie, MD 21060 Dorothy C. Jackson/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12/17/2011 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Harmony Memorial Park 12/16/2011 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Sign wire f Funeral Service Licens 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 13 years Immediate Cause (Final Physician/ Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it day, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown icate has been sig r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate l 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work' XNatural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 24 hours a Funeral I Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 12/08/2011 D43083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive, Rockville, MD 20850 George A. Sotos, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # 29d Per PHY G922 12/15/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 2 Year CAPLAN PEARL Medical nm 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE BALTIMORE COURTLAND GARDENS If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 X F 0472171919 92 Director 213-38-8403 VA Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 7920 SCOTTS LEVEL ROAD 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 δ If Yes, Give Year or Dates 1 Yes 2 XNo Specify Specify: 3 ₩ Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NURSE NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ YETTA LEVIN WALMAN and 2 should the Health and Me tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN CORNBLATT/DAUGHTER 3041 FALLSTAFF ROAD, UNIT 404, BALTIMORE, MD 21209 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ISRAEL CONGR. 12/14/2011 BALTIMORE, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Physician/ 6 Mory disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 as IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the 9 Unknown ģ Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 00 1 Tyes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 autopsy performed Hospital or Attending Physician: The certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No death Accident within 24 hours after death To the Funeral Director: / completed filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur Date signed (Month, Day, Year) 2011 and tale of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7920 SCOTTS LEVEL ROAD, BALTIMORE, 21208 SUNIL RAJANI, MD31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BENNIE 10:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNIV. OF MARYLAND BALTIMORE CITY BALTIMORE CITY MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min 228-36-0581 1 **X**M 2 \square F **Director** 06/20/1925 Virginia 86 Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and once. 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 XYes 2 No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 920 Bennett Place 21223 U.S.A. and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ementary/Secondary (0-12) College (1-4 or 5+) 12th grade MD Cup Co. Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Darden Mattie Person 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Darden(Daughter) 920 Bennett Place, Baltimore, MD 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date . Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Cem. 12/15/11 Baltimore, MD permit. 21. Signature of Funeral Service Licensee Joseph Address of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, PA MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EXACERBATION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter consensing Cause (Disease or injury Examine Due to (or as a consequence of): for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, CANCER WITH LUNG 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ADPTIC STONOSIS 24a. Was an autopsy performed Yes 2 2 No 1 Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 **N**O 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D50544 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIV. OF MARYLAND MEDICAL AMAL m D 31. Date filed (Month, Day, Year) 32. egistrar's Signatur State

DHMH 17 Rev 06-2011

Registrar

DEC

Please Type of Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | |

40020 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical HELEN MAE EARP December 2011 9:55 Ρ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 7944 Savage Guilford Road Howard Jessup If Under 1 Year | Tif Under 24 Hrs. **Funeral** 2107ial 48urit34451er 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2**X** F Months Days Hours Min (Month, Day, Year Director 09 98 2. May 1913 Maryland Usual Residence of Decedent 28a-f show ms 23a or 28a-f shormust be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Savage Guilford Road 7944 20794 within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. an "natural", or iter Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Completed 3x Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12th Ø Homemaker Own_Home event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ည Calvin Ross Ramsburg Sadie Mae Burdette and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 i John R. Earp, Jr. / Son 17024 Frederick Road, Mt. Airy, MD 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 Date 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Poplar Springs Cem. 12/16/2011 Mt. Airv. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one lause in each line. Approximate Interval Between Onset and Death Immedian Cause (Final Physician/ disease or condition resulting in death) Multiple Myeloma vrs Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 the nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ò Month Pregnant at time of death Dav Year detached g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Septicemia, Coronary Artery Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Thrombocytopenia 24a. Was an has page death? performe certificate Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🗓 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Funeral Director: 6 Could not be Suicide 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Karage Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD December 13, 2011 D22755 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine DeLima, MD 7350 Van Dusen Road, #260 Laurel, MD 20707 31. Date filed (Mo 32. Registrar's State 5 2011 DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ 0347 M onald Evans 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin, MD Atlantic Hospin Novceste General If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sept. 5, 1939 7. Age (In yrs. last birthday) Funeral Days Hours 1 **X** M 2 □ F 72 218-36-3853 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA Funeral 48 Coastal Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Force Black White etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Gov. Firefighter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Raymond F. Evans, Sr Frances Elizabeth Filippino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 225 Worthmont Road; Catonsville, MD 21228 Ronald Joseph Evans, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 12/14/2011 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 1. Sign ture of Funeral Service Licentes 23a. Pard. Enter the disease or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cooking to introduce cause. Enter Underlying Examiner The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Hypertrophic Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 Yes 2 g Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Hypertension 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipide mia autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No certificate 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 XER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral work? 1 ☐ Yes 2 ☐ No iniury 1 Natural 5 \square Pending Accident Suicide Investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month) d0067227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11107 Ragetrack Rd Belin, MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year).

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2. Registrar's Signafure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death John W. Evans Jr 12/10/2011 Physician/ 08:45a M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Prince George's Laurel 501 Main Street Apt 416 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🔀 M 2 🗆 F Days Hours 05/2071933 578-42-9888 78 NY Director Usual Residence of Decedent or 28a-f show s notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No MD Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 0 "natural", or items 23a o edical Examiner must be USA Funeral 501 Main Street Apt 416 20707 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, GiveKorean Year or Dates. War Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired; Security Guard Elementary/Seconday (0-12) College (1-4 or 5+) 4yrs Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marita Estelle Evans မ John Wilfred Evans Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan Terrell Sister 15708 Tierra Dr Silver Spring MD 20906 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Atlantic Crem 1 Burial 2 X Cremation 3 Removal from State 12/12/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service License ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Lung Cancer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: . nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 roonths? Year Month Dav Pregnant at time of death n signed by the a ld be detached fo 1 Yes 2 9 Unknown Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Ischemic Heart Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Airway Obstruction Disease 24a. Was an autopsy has performed? Yes 2 \(\Delta \) No page 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\overline{\pi}\) Residence 6 \(\sum \) Other (Specify) 2 XNo ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work 1 X Natural 5 Pending n 24 hours after death.

e Funeral Director: Afteleted filled in by the fur Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Kouakchou, md 12/12/2011 jocetyne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou 4041 Powder Mill Road Suite 600 Calverton MD 20705

DHMH 17 Rev 7/2009

State Registrar DEC 1 5 2011

31. Date filed (Month

2. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12:05 2011 Alice Jean Fitch December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a 1050 E. 33rd Street Apt. 304 Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday **Funeral** 1 🗆 M 2 💢 F Month Day Year) MD **Director** 213-36-5766 Usual Residence of Decedent 3a or 28a-f shov t be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1

Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ,s 23a o, c must b Funeral USA 21218 1050 E. 33rd Street, Apt. 304 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or itel Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 XNo Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Schools Food Service 10 Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Moore Henry Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1050 E. 33rd Street, Apt. 304, Baltimore, MD 21218 Lorenzo Fitch Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 12-16-2011 Woodlawn, MD Fune al Service Line nsee 22. Name and Address of Facility Wile Fineral Time P.A. of Baltimore Co. 21. Sign 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYDCARDIAL Physician/ ACUTE MINUTES disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? Completed by HYPOTHYROIDISM 1 Yes 2 No 3 Probably 4 Unknown peen SARCOIDOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has I I director, page 2 s autopsy perform 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\text{Yes} \) 2 \(\text{No} \) No Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{P}\) Residence 6 \(\sum \) Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident after death

Director: / Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aff

To the Funeral Di

completed filled in Medical 1 Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 040480 DECEMBER 2011

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State Registrar filed (Month, Day, Year) 32. Registrar's Signatur

FERNANDO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fenno

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21236

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	4	For State	,	partment of Health and N ertificate of Death							
		Registrar 1. Decedent's Name (First, Middle, Last)		ertificate of Death	Reg. 2. Date of Death	No. 2 0 3. Time of Death					
Physicia	n/	JOBIE	GAUSE		Month DECEMBER	Day Year 6:45PM					
Medic Examin		4a. Facility Name (if not institution, give s		4b. City, Town, or Location of Death		4c. County of Death					
<i>I</i>		TRANSITIONS 1	HEALTH CARE 7. Age (In yrs. last birthda)	SYLESVILLE		CARNOLL					
Funeral Director		4	/	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	, 10					
		Usual Residence of Decedent	M 2 □ F 65 Yrs		09-14-1	1946 SOUTH CAROLINA					
/land f show ed at	tor	10a. State 10b. County	10c. City, Town or			10d. Inside City Limits 1 Yes 2 □ No					
e Maryk r 28a-f notifiec	Director	MD	BACT	100 RE	100	Citizen of What Country?					
s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at		4017 The AlA	MEDA	21218	109.	USA					
eath w	Funeral			Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,					
fter de , or it amine	þ	1 Never Married 2 Married	Black, White, etc. Specify: BLACK								
ours a tural	sted	3 Widowed 4 Divorced 15. Decedent's Ed	If Yes, Give Year or Dates.	1 ☐ Yes 2 🗷 No Specify:	401						
72 hc in "na Medic	Completed	(Specify only highest grad	de completed) (Gi	ve kind of work done during most of work . DO NOT use retired)	king	b. Kind of Business/Industry					
filed within 72 hours after al Hygiene. I other than "natural", or event, the Medical Exami		Elementary/Secondary (0-12)	College (1-4 or 5+)	ABORER	7/	MELTING CO.					
1 and 2 should be filed within 72 hour f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical	To Be	17. Father's Name (First, Middle, Last)	50		ne (First, Middle, Maid M. Mc.(_					
d Men d Men marke	-	Jobie L. Gause,		ailing Address (Street and Number or Rui							
2 sho Ith an 27 is r		Rose A. GAUSE		7 The Alameda	BALTIN	10RE, MD 21218					
1 and 1 and of Hea item		20a. Method of Disposition	20h Place of Di	ensoition /Mamo of	Data 20	Location - City or Town State					
Page 1 nent of ant: If it ury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State GARRUS	NFORET 12/	22/11 B	ALTIMORE, MD					
permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service License	ee .	22. Name and Address of Facility VP	TUBHN 61	REENE FUNERAL SUS More, MO. 21212					
		23a Part 1 Enter the disease or comp	lications that caused the death. Do not	TYVS JORK KOAT enter the mode of dying, such as cardiac	or respiratory arrest.	Approximate					
I MANAGEMENT		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		o, respirator, a,	Interval Between Onset and Death					
Medical		Immediate Cause (Final disease or condition resulting in death) a. UNG CANCEA Due to (or as a consequence of):									
Examiner	L	Sequentially list conditions, b.									
p to	xamine	if any, leading to immediate cause. Enter Underlying									
ecuted and il-transit	Exan	Cause (Disease or injury that initiated events resulting in death) Last									
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ficate g phy as the	Nedi	Le setting									
ath certificate be exe attending physician of for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year					
deat the att	ysici	1 Yes 2 No	4 ☐ Pregnant at time of death g ☐ Unknown	5 Other (specify)		Month Day Tour					
at the		Part II. Other significant conditions co	ntributing to death but not resulting in t	ne underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?					
Jires th	ed by				1 Yes	2 No 3 Probably 4 Unknown					
w requ	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
The la ate ha	Com				performe	d? death? 1 Yes 2 No					
cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Che							
Physi this c	2	1 Yes 2 No	1 Inpatient 2 ER/Outpa	atient 3 LI DOA 4 LI Nursing F	ome 5 Residence 28d. Describe how	e 6 Other (Specify)					
nding tth. : After e fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) inju	ry work? M 1 ☐ Yes 2 ☐ No							
Atter er des ector by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined		street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bu											
Hosp 24 hou Funer stely fil	Medical	(Chack 2 Medical Evami	nor: On the basis of examination and/or in	ath occurred at the time, date and place, avestigation, in my opinion, death occurred at the time, date and recovered at the time, date and recovered at the time.	at the time, date and p	place, and due to the cause(s) and manner stated.					
omple	ž	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	e Practitioner: To the best of my knowle	dge, death occurred at the time, date and p 29c. License number		ause(s) and manner as stated. I. Date signed (Month, Day, Year)					
F S F O		1	M.D.	057722	- 7	DELEMBER 14 2011					
A		30. Name and address of person who o				the second secon					

State Registrar 31. Date filed (Month, Day, Year)

DEC 1 5 2011

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M.D. 1838 GREENE TREE ROAD # 300 PILLESVILLE MP 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ DECEMBER 2:50 AM Leroy Green 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MISPITA COF BACTIMORE ISALTIMORE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** MD **Director** 1 № M 2 🗆 F TEY Yrs. or 28a-f show 10d. Inside City Limits 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland Director Oak Baltimore GWYNN 1 🗆 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21267 Roaers Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Transportation Elementary/Secondary (0-12) Driver Truck 2th grade 17. Father's Name (First, Middle, Last) other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sulmame) ဂ္ Mildred Moore Sidney Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other tratonce. Rogers Avenue Giving Dak MD 21207 twilda Kay Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemeters, crematory or other place) 1 → Burial 2 □ Cremation 3 □ Removal from State Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) M.C. Greene Funeral SVO Signature of Funerart Service Licensee laug iberty Road Randallstown MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final MYUCARDIAL INFARCTION Physician/ UTE days disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading limited to cause. Enter Underlying Physician/Medical Examiner Due to lor as a consequence of Shp Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗀 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant Month Day 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by CEREBROVASCULAR REGIDENT 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of DIABETES MELLITUS TYPE II 24a. Was an has autopsy page 2 performed? death? Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best only included, such account of the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ECEMBER 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

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32. Fegistrar's Signature

SINAI HOSPITAL OF BACTIMORE

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1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2/13/2011 Gayle Cleon Physician/ 12:20pm M Medical 4a. Facility Name (if not institution, give street and number) 9632 Washington Street Town, or Location of Death 4c. County of Death Examiner Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 072–74–4191 8. Date of Birth **Funeral** Min. 1 □ M 2 🔀 F Months Days Hours (Month, Day, Year) 11/30/49 Kingston, Jamaida Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Laurel Howard notified MD 28a-f 1 Yes XX No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö ms 23a or must be n 20723 Funeral 9632 Washington Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14. Race - American Indian Race - Allie... Black, White, etc. Black "natural", or item edical Examiner r Armed Forces? þ 1 Never Married XX Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Payroll & Personal Coordinator Be 18. Mother's Name (First, Middle, Maiden Surname) Mary Roselda Mason 17. Father's Name (First, Middle, Last) th and Mental H 27 is marked ot traumatic ever 2 Mary Guy Keith Earle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 229 Farleigh Ct., Langhorne PA 19047 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Oswald Aleka 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Rosedale Mem. Park 1 Burial 2 Cremation 3XXRemoval from State 12/17/11 Bensalem. 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service Licensee Victor P. Doda 14 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death small cell Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) spital or Attending Physician; The law requires that the death certificate be executed tran and Due to (or as a consequence of): physician ar s the burial-t resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 1 🗆 Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural Coldent Suicide 5 Pending work?
1 Yes 2 No s after death.

I Director: Aft din by the fur Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D23743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARTION WEETS TSSE (FORWAY CT Do GEORDOH)

70 32. Registrar's Signatur

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ 1255 AM 201 l NILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE OF MARYLAND MEDICALGA UNIVERSITY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 192-30-2733 Hours Director 1 **X** M 2 □ F 1940 PA 8 11 Usual Residence of Decede or 28a-f show notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director PA Berks Reading 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 23a Funeral 253 Seidel Street 19606 USA items ; . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. tent if item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner muliury or other traumatic event, the Medical Examiner mulius or other traumatic event, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
Yes 2
If Yes, Give Black, White, etc Unk. 1 Never Married 2 X Married 2 No Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Mac Trucks/Transportation Elementary/Secondary (0-12) 12 College (1-4 or 5+) Dir. of Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Susan Hascin John Gmitter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 253 Seidel Street, Reading PA 19606 Karen Gmitter /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ardent Crematory 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 12/12/11 Hanover MD 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service Licensee Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final RESPIRATORY Physicania HYPOXIC disease or condition resulting in death) Medical Due to (or as a consequence of Examiner THIRGOID a withbrood tall effective re-Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Other (specify) Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes 2 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 \square Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce 29d. Date signed (Month. Day, Year) D 68808 MD 8/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATIMORE S MD GREENE 32. Registrar's Synature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death L0028 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12^{pay} 8:30p M Dec. Physician/ James Leo Gorman Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Middle River Baltimore 13223 E. Greenbank Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 7, 1922 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 462-28-0920 **Director** 89 1 3M 2 F Texas 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 'natural", or items 23a or 28a-f sho dical Examiner must be notified at Director MD Baltimore Middle River 1 Tes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 13223 E. Greenbank Road 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: If Yes Give Specify White 3 XWidowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Beth Steel the 2yrs Electrian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental F marked o ဂ္ ont of Health and Menta it: If item 27 is marked y or other traumatic e James Leo Gorman Sr. Demie A. Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 13223 E. Greenbank Road Baltimore MD 21220 Jessie Howard /grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12/19/11 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Department of Important: If any injury or Belair Memorial Belair MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sign of re of Funeral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ UREMIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner FAILJME NENAU CHROMO Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate NEPWAORATHY cause. Enter Underlying Cause (Disease or injury DIABETIC Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last YRS. attending physician Physician/Medical DIARETES Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No for Year Month Day Pregnant at time of death detached 1 Yes 2 L Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPENTENSIVE page 2 should be CARDIOVASCULAR 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 \sum Yes 2 \textbf{X} No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 2 D18642

68

Registrar

DHMH 17 Rev 06-2011

person who completed cause of death (Item 23a) (Type, Print)

Pan Came M, M, D

32. Registray's Signayore

9518 Philadolphia nd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20^{Pay} Month Physician/ 20ÎÎ 3:10A M Katie B. Granger Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Montgomery County General Hospital 01nev 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours Louisianna 433-38-6565 89 Director Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2XXNo MD 01nev Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 "natural", or items 23a or Funeral U.S.A. 3729 Gelderland Court 20832 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify. White Completed 3 X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Biagas Ora Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18616 Chanlee Mill Road Sandy Spring, Maryland 20860 Charlene Thornburgh (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🕱 Burial 2 🗆 Cremation 3 🕱 Removal from State Sacred Heart Cemetery 11-21-2011 Lake Charles, LA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. Signature of Funeral Savi e Licensee M01050 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Extend the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Due to (or as a consequence of and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year for Month Day Pregnant at time of death Other (specify) the t g Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy perform 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? 2 No 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending 2 🗌 No hours after death Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December Bichhum V54996 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bichhuony Jinh 18101 Prince Philip Drive Olney, MD 20852 31. Date filed (Month, Day, Year)

State

Registrar

5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 13 ^{Day} 2011 Year Physician/ 8:18 A M Elizabeth Ella Groff Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 44 West Green St. Westminster 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min 190-12-9680 90 Director 1 🗆 M 2 🔀 F 12-12-1921 PA Yrs Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Carroll Westminster 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21157 USA 44 West Green St. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō by 1 Never Married 2 Married 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify. Specify: white "natural" 3 X Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. within 7 Elementary/Secondary (0-12) College (1-4 or 5+) Equipment Business Owner 8 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of P Mabel Sentman John Warfel t. Page 1 and 2 should be thent of Health and Mertant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158Cassandra Inskeep_Daughter 1170 Silver Run Valley Rd., Westminster, MD other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or c cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 12-14-11 Sykesville, MD 22. Name and Address of Facility Fletcher Funeral Home, homas atter. 21157 254 E. Main St. WEstminster, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 XNo
9 Unknown that the death Year Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The law requires 1 Yes 2 No 3 Probably 4 Unknown Thyroid Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an autopsy performed? Yes 2 K No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\mathbf{X} \) Residence \(6 \) Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death s after death. 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 12/14/2011 D0037384

Registrar

Maryland 21215-0036

Baltimore,

68760

Box

P.O.

Records,

Division of Vital

State

Westminster, MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 826 Washington Rd.

32. Registrar's Signature

Jocelyn Swanson-Apollon, MD

31. Date filed (Month, Day, Year)

DEC 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40031 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death のユーザ 🖁 A M 2. Date of Death Year Month Day Gorha DECEMBER institution, give street and number) Town, or Location of Death 4c. County of Death If Unde 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign County) 8. Date of Birth If Under 24 Hrs. Days 1 🗆 M 2 💢 F Months Hours Min Yrs 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 ☐ No timore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11. S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 📈 No Specify: Specify: Slack 3 ₩ Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) essex Tea 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 a 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 D Burial 2 Cremation cemetery, crematory or 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens ervice 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CANCER UNG disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

Funeral Director

þ

Completed

Be

မ

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine

Physician/Medical

Completed by

Be

ပ္

Certificate:

Medical

signed by the attending physician and I be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that t within 24 hours after death.

To the Funeral Director: After this certificate has been signed b page 2 completed filled in by the funeral director,

Division of Vital

Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant

3c.	If yes, outcome of pregnancy
	1 Live Birth 2 Fetal de
	4 Pregnant at time of deat
	9 Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an performed? Yes 2 N

MD

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

25. Was case referred to medical examiner? 1 🗌 Yes 2 🔀 No 27. Manner of Death

Hyperlipidemia

in the past 12 months?

1 Yes 2 No

1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 5 Pending Investigation Could not be

determined

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 2 🗌 No 1 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

70

BALTIMORS

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DECEMBER

21229

28d. Describe how injury occurred

29a. Certifier (Check 2 L only one)

1X Natural

Accident

Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9003.CATON CEDRIC Drisk

31. Date filed (Month, Day, Year) DEC

2. Registrar's Signature

State

28b. Time of

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40032 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 12-11-2011 Physician/ John 10:30a^M Giza Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4613 Asbury Avenue N/A City Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 213-26-0373 Director 80 1 🛛 M 2 🗆 F 2-12-1931 Maryland 28a-f show 10d, Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 X Yes 2 No MD N/A Baltimore City 10e. Street and Number 10g. Citizen of What Country? ò 23a Funeral 4613 Asbury Avenue 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc ori 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White "natural", 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Western Electric Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Stanley Giza Tillie Danielak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Theresa Giza/Wife 4613 Asbury Avenue Baltimore, MD 21206 or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot $12 - 14^{-1}$ 1 🛮 Burial 2 🗌 Cremation 3 🗀 Removal from State Baltimore, MD St. 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee mo0933 Roberton 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE disease or condition Medical resulting in death) Examiner RONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to jor as a consequence of death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ed by the a 9 Unknown Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STENOSIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ABDOMINAL has autopsy perform 2 🗌 No 2 **X** No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 X Natural 5 Pending iniury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, upletely filled in by determined building, etc. (Specify) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 31230 12-12-2011 30. Name and address of person who completed cause of death (Item 2) a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Robert

V.

31. Date filed (Month, Day, Year)

Zawodny,

St

Paul Street Baltimore, MD 21202

301

M.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December Day 11. 2011 2:05P M Harris Susan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Ridgeway Manor Nursing Home Catonsville Social Security Number **Funeral** 7. Age (In yrs. last birthdav If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye July 5. 1 Birthplace (State or Foreign Country) Months Days Hours 1 M 2 X 401-34-2331 **Director** 85 July North Dakota 1926 Usual Residence of Decedent or 28a-f show notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Bart: If Ifew 275 is marked of other than "natural", or items 23a or 28a-f show lury or other traumatic event, the Medical Examiner must be notified at Jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 227 West Medwick Garth 21228 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည George Perzinski Anna Malarchek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Harris, III Son 227 West Medwick Garth; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Holy Redeemer Cemetery 12/14/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke MOILS 1630 Edmondson Avenue; Catonsville 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Hopeteusial A terio sclenotie Coman Opioin Disione Onset and Death Physician/ 40,000T Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): burial ned by the attending physician detached for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> denouta 2 No 3 Probably 4 D Onknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1
Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 966 12-13-2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) Gen Biner, Mayland 20061

State Registrar 31. Date filed (Month, Day,

Year

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Registrar's Signatue

+ 508

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State 40034 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2011 7:25 AM Estella Elizabeth Hicks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Prince George Cherry Lane Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) **Funeral** Months Days Hours Min Apr 15, 1 □ M 2 🛱 F Year 934 Texas Yrs Director 437-46-6094 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director r 28a-f s notified 1 X Yes 2 No MD Greenbelt Prince George 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? .1s 23a oı •r must b Funeral U.S.A. 5823 Cherrywood Lane #201 20770 tems "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: ^{Specify}African American 3 Widowed 4 Divorced Completed er than "natur , the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Public Schools Ith and Mental Hygier 27 is marked other traumatic event, thu 4 Ed<u>ucator</u> Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be TC Davis Sylvia Boykin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 s ment of Health a t: If item 27 i 7903 Orion Circle Unit 340H, Laurel, MD 20724 Johnnye Yvette Hicks /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Maryland Nat Mem Pk | Dec 16, 11 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Mar Signature of Funeral Service Licenses 1-10-61 Maryland 20707-4389 M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear, failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ weeks disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of) Examiner 1 month Cardiomyopathy Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury burial-transit 2-3 months End stage renal disease that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial requires that the death certificate be ex Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 🔀 No the Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Diabetes Physician: The law certificate has autopsy page performed' Hypertension 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗓 No After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 잍 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending 5 Pending 1 X Natural s after death.

I Director: Af
d in by the fu 1 Tes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined nin 24 hours afte the Funeral Dire Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

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Within 2
To the I

only one

31. Date filed (Month, Day, Year)

29b. Sign

ure and title of certifier

R-TTENDING

3450 Ft. Meade Road, Laurel, Maryland 20724

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HTSI CINN

2. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

Parke

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0057216

29d. Date signed (Month, Day, Year)

Dec 9, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 40035 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ R Medical 4c. County of Death **Examiner** 40W AN 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-20-Director 1 - M 2 - F 28a-f show 10a. State 10d. Inside City Limits with the Maryland Funeral Director notified 1 Yes 2 No 0 10g. Citizen of What Country must be n ral", or items 2 Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK of Health and Mental Hygiene.

item 27 is marked other than "natural",
other traumatic event, the Medical Exa Completed 3 Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PRICE ည 19a. Informant's Name/Relationship (Type, Print) VAUINTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2320 SIENIA WA WoodSTOCK.MDZ1163 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If ii any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, DWINGS MILLS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DAUS disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transi Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day been signed by the a should be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an After this certificate has funeral director, page 2 : autopsy performed? Yes 2 2 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No HOSPICE 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🗷 Natural 5 Pending Investigation Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 164395 DECEMBER 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIELLE DOBERMAN, MIS COLUMBIA, MD 21044 6336 CEDAR LANE

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1 5 2011

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40036 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 600 M Month Physician/ 201 OSZNA Medical 4b. City, Town, or Location of Death 4a. Facility Name (i not institution, give street and number) County of Death **Examiner** a tonsu Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) **Director** 1 **2** M 2 \square F orth 3a or 28a-f show t be notified at 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MOYA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o Funeral 3703 Seg U.S. A 212/1 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. o by 1 Never Married 2 Married should be filed within 72 hours after a land Mental Hygiene.

is marked other than "natural", or 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life., DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Vecto traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည tinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 C a SOL 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) ot 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of F 21. Signature of Funeral Service Licensee 701 23a. Part 1. Enter the disease, or complications that caded the death. Do not enter the mode of dying, such as cardiac Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ HYPERTENSIVE CARDIO VASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to him recent cause. Enter Underlying Cause (Disease or injury Examiner Directo (or as a nonsequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KIDNEY DISEASE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No this certificate 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

210 BusiNESS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 19 Derember 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospita andulistown Baltimo Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Country) UKRAINE 1 XM 2 □ F Davs Hours 0972874929 82 Director 217-39-9852 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City. Town or Location Director 1 Yes 2X No OWINGS MILLS MD BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 104 PLEASANT RIDGE DRIVE, #412 21117 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. 6 Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No "natural", Specify: 3 Widowed 4 Divorced WHITE the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) 5+ Elementary/Seconday (0-12) CONSTRUCTION CONSTRUCTION MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ IOFFE TARNOPOLSKAYA IDA 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL MATOV/SON GILLINGHAM COURT, OWINGS MILLS, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/14/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility . Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any leading to immediately cause. Enter Underlying Due to for as a consequence of Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician المعاودة : page 2 should be detached for المعامدة على الم Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 1 Yes 2 9 Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Nonknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 M 24a. Was an autopsy Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗌 No ျ R/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Anatural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated fertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signatu 29d, Date signed (Month, Day, Year) D3062650 and address of person who completed cause of death (Item 23a) (Type, Print) Vandailstown MD

State Registrar

gnure 31. Date filed (Month, Day, Year)

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Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DÉCEMBER 12, 201 ANTHONY **JAMES** JARCEWSKI 11 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LEVINDALE NURSING HOME N/A BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Months Days Hours 4 - 18 - 1 921 MARYLAND **Director** 217-22-2185 90 Yrs Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE ROSEDALE 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 503 PATUXENT AVENUE 21237 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ö þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) TRACTOR OPERATOR BETHLEHAM STEEL other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam n and Mental } မ JOSEPH **JARCEWSKI** HELEN POTOMSKA) and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ROSEDALE, HELEN J. JARCEWSKI/WIFE 503 PATUXENT AVE 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) OAKLAWN CEMETERY 12-16-11 BALTIMORE, MD of Funeral Service License 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of resulting in death) Last attending physician for use as the bunal Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 2 🗌 No q 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has l autopsy performed certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; to 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of Certificate: 28c. Injury at 1 thatural injury 5 Pending 1 Yes 2 No Accident Investigation □ Accider
 □ Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

5 2011

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland Bepartment of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 63CP M Physician/ عر neko Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** Baltimore Randallstown Season's Hospice Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Hours 75 219-38-9676 1 □ M 2 🔏 F **Director** Yrs. 36 80 06 Japan Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1X Yes 2 No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 must be items 23a 21207 U.S.A. 19 Tomber Ct. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2X No Black, White, etc. o þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes X No Specify: If Yes, Give Specity Japanese "natural", 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Man Elementary/Secondary (0-12) College (1-4 or 5+) House Wife 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jen Mikajiri Sunao Abe' 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19 Tomber Ct., Baltimore, Md 21207 19a. Informant's Name/Relationship (Type, Print) Bobby Samuel Jackson-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Owings Mills, Md 12/21/2011 Garrison Forest ature of Funeral Service Licenses Name and Address of Facility Baltimore, Md 21215 4300 Wabash Ave, 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate ock, or heart failure. List only one cause on each line Interval Between Onset and Death nediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any loading to in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examir attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed Yes 2 death? ☐ Yes 2 ☐ No certificate 25. Was case referred to edica 26. Place of Death (Check only one) or Attending Physician: funeral director, Be examiner? ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No of Death 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 5 Pending iniury 1 Natural Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined. Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie MA 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 40040 State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201^{Year} December 4:45 AM Amy Collins Jessie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Yea. Apr. 9, 1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days Months Hours 205-28-7903 **Director** 1 □ M 2 🗓 F 77 1934 Pennsylvania or 28a-f show the notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fiem 27 is marked other than "natural", or items 23a or 28a-f sho important: I fiem 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director VA Middlesex Urbanna 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8664 Tidewater Trail 23175 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give **Black** 3 X Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Supervisor Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Richard Collins Sarah Amy 3b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13505 Winding Trail Court Silver Spring, MD 20906 19a. Informant's Name/Relationship (Type, Print) Sheila J. Jackson-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mount Zion XBurial 2 Cremation 3 Removal from State 4 ☐ Bonation 5 ☐ Other (Specify 12-10-2011 Middlesex County, VA Cemetery 21. Sigrature of uneral Service Licens 22. Name and Address of Facility J.K. Redmond Funeral Home ▶ 3632 Lewis B Puller Memorial Hwy,Shacklefords,VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph sician/ Leukemia - T-cell Prolymphocytic months disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the bunal-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 28 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 X No 3 Terobably 4 Tendenthal Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Hospital 2 XNo Other: 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending I Director: A 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 06-2011 29b. Signature and

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Regierar's S

William King Kelly,

2011

29c. License number

1400 Forest Glen Rd., Silver Spring, MD

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

40041

			For State Registrar	State of Mary		rtificate of			leg. No.		
ı	Dharisis	.,	Decedent's Name (First, Middle, Last))				2. Date of Deat	:h	Year	3. Time of Death
	Physicia Medic		LEANNA KO					Decembe	1	2011	8:59 A M
	Examin	er	4a. Facility Name (if not institution, give submitted that the submitt				or Location of Deatl	1	4c. Coun	ty of Death	
y "	Funeral		5. Social Security Number 6. Sec		yrs. last birthday)	If Under 1 Year Months Days			Year)		lace (State or Foreign
	Director		217–38–9182 ₁ [Usual Residence of Decedent	☐ M 2 💢 F	69 Yrs.	Month of Early		August 31	,1942	Mary.	Land
	and show	ior	10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Maryl 28a-f otifiec	irec	Maryland N/A		Balt	imore					1 X Yes 2 □ No
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 3023 Elm Avenue			10f. Zip Code	21211		10g. Citizen o US		try?
	eath w	Fune	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of I	Hispanic Origin? (Spoan, Mexican, Puert	pecify Yes or No-		ace - Americ	
20	after d I", or i camin	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4X Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		1 Yes 2X N		o riicari, etc./		ack, White, of the state of the	
9500-612	natura ical Ex	Completed	15. Decedent's Ed	Year or Dates.	16a. Dece	dent's Usual Occu	pation		16b. Kind of		
۲۱ ۲۱	tin 72 l te. han "r e Med	ошо	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. E	OO NOT use retired	during most of world)		Doval	Farm	
ב	ed with Hygier other t	Be C	12 years 17. Father's Name (First, Middle, Last)		Aud	itor	18 Mother's Na	me (First, Middle, N	Royal		
<u>lan</u>	i be filed fental Hy rked oth tic event	10	Cecil Nine Sr.					e Spiker			
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Typ			ng Address (Street	t and Number or Ru nue, Balt	ral Route Number,	City or Town	, State, Zip (2121	
	1 and 2 soft Health item 27 other tra		Kimberly Koehler-I	1/	20b. Place of Disp	osition (Name of	1		20c. Location		
JOE L	it. Page 1 utment of ortant: If it njury or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State .	cemetery, cre	matory or other pla 11 Memori		ember 2011 1	MIddle		
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		21. Si, nath e of Etheral Service License				Funeral Lers Poin				
n	8 3 E 6 8		23a. Part 1. Enter the disease, or comp	Connec						<,MD.	21222 Approximate
	hysician/		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	death, bo not en	er the mode of dy	ing, such as calcula	or respiratory are	501,		Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as a co	onsequence of):	سدر					1 weeks
	Examiner	Į.	Sequentially list conditions,	b							
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):						
	certificate be executed anding physician and use as the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
760	ate be ohysici the bu	edical		d							
g	certific nding p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		7			23d. l	Date of deliv	ery
BOX	death of	Physician/M	in the past 12 months? 1 ☐ Yes 2 ※ No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	□ Fetal death 3 ne of death 5	□ Ectopic pregnar □ Other (specify) □	ncy		ľ	Month	Day Year
0	at the d by the	Phy	9 ☐ Unknown Part II. Other significant conditions co		not resulting in the	underlying cause (given in Part I.	23e. Did to	bacco use co	ntribute to t	ne cause of death?
S, F.	law requires that the nas been signed by the e 2 should be detach	d by	asthm	a				1 00	′es 2 □ No	3 🗆 Pro	bably 4 🗌 Unknown
Vital Records,	w requase been 2 shou	Completed	COPD					24a. Was a		prior to co	psy findings available impletion of cause of
Ř	The la	Com						perfor 1 Yes	med?	death? 1 Yes	2 🗆 No
Ita	sician; certific	Be .	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	o P(= n / o)	Ot	Place of Death (Che		• • • •	41(0	
0	g Physer this	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Ye	2 K ER/Outpatie 28b. Time of ear) injury	of 28c. Inju		Home 5 Residence 28d. Describe ho			//
on	tendin leath. or; Aft the fur	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 [Yes 2 No	ļ			
Division of	lor At after c Direct d in by		4 Homicide determined	28e. Place of Injury - building, etc. (S		reet, factory, office		28f. Location (S City or Town		nber or Rura	l Houte Number,
_	To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		ician: To the best of my							ed. luse(s) and manner stated.
	thin 24	Me	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practitioner: To the b	est of my knowledg	e, death occurred a	t the time, date and	place, and due to th	ne cause(s) an 29d. Date sig	d manner as	stated.
	¥ ¥ ¥ 8		12	In Un	1/ 4	7	15409	8	12/1	3/11	//
	Ju		30. Name and address of person who g		h (nem 23a) (Type,	Print)	() ()	~	4 - 10		211
	· V		DENIS W. MacD. 31. Date filed (Month, Day, Year)	ONALD M.D	2801 F.	UDSON.	St SteC	BALTO	MD	3/30	77
	Sta Registr		DEC 1 5 2011	we d.	Signature		_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40042 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 12 Month 3. Time of Death Physician/ 201°1 12 ROBERT MONROE KNIGHT 12:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 105 Southview Lane Pasadena Anne Arundel 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **Director** 480 16 4269 1 🗷 M 2 🗆 F 89 08 04 1922 Iowa Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Eart: If item 27 is marked other than "natural", or items 23a or 28a-f shou ruy or other traunatic event, the Medical Examiner must be notified at ury or other traunatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Pasadena 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 105 Southview Lane U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1943 If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed 1945 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Railroad Engineer B & O Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Milburn Knight Marie Ella Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Knight - Son 105 Southview Lane Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 12/17/11 Glen Burnie, MD 21. Signature of Eurer envice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA 169 Riviera Drive Pasadena, MD 21122 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Hyteriosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) Examiner abeter mell Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): ed by the attending physician detached for use as the buris Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.

Funeral Director: After this certificate has been signed by the attending adversarian P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Tetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signing page 2 should be Division of Vital Records, 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsv performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signatur title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 26203 1105 mo d address of person who completed cause of death (Item 23a) (Type, Print) 110 4000 Annapolis Rd Baltimore 21227

DHMH 17 Rev 06-2011

Registrar

State

Date filed (Month, Day, Year)

DEC 1 5 2011

32. Registrar's 5 gnature

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			For State		State of M	aryland		artment of H		vientai Hy	giene	201	1 40043	
_			Registrar				Cer	tificate of D	eatn	_	Reg. No	<u>. 201</u>		
	Physicia	n/	1. Decedent's Name		,					2. Date of De Month	ath Da	ay Year	3. Time of Death	
	Medic	al		B. Kumme				# 0" T	Lucation of Death	12	1	201		
	Examin	er	4a. Facility Name (if r	AGNE		7 7 A	1	4b. City, Town, or	TIMO	06	40	c. County of Deat	п	
			5. Social Security Nu	ımber 6. S	Sex 7. Ac	ge (In yrs. las		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	g, Bir	thplace (State or Foreign	
	Funeral Director		236-32-8	1 4	□ M 2 🖾 F	86	Yrs.	Months Days	Hours Min.	Sept.	16°,1	.925 Wes	t Virginia	
	*		Usual Residence of I	Decedent										
	/land f sho	후	10a. State	10b. County		10c. City,	Town or Lo	cation					10d, Inside City Limits	
	Man, 28a- otifie	<u>ië</u>	Maryland	Howard		E111	cott						1 🗆 Yes 2 🔀 No	
	h the	al D	10e. Street and Num					10f. Zip Code				itizen of What Co	ountry?	
	thin 72 hours after death with the Maryland nne. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at.	Funeral Director		ings B e n		F	10.1	21042 Was Decedent of His	mania Origin? (Sp	acify Vas or No-	USA	14. Race - Ame	vices Indian	
	r dea or ite iner		 Marital Status Never Marrie 	ad 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 X		13.	f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		Black, White	e, etc.	
336	s afte al", c Exam	d by	3 🖾 Widowed 4		If Yes, Give Year or Dates.	1110		I ☐ Yes 2 🔀 No	Specify:			Specify: Wh:	ite	
9	hours natur lical	Completed	(0	15. Decedent's I	ducation	- 1	16a. Dece	dent's Usual Occupa	ation	Vina	16b.	Kind of Business	Industry	
25	in 72 e. nan "	틹	Elementary/Seco	cify only highest gr anday (0-12)	College (1-4 or	5+)	life. D	kind of work done di O NOT use retired)	unng most of wor	ang	_	**		
2	with gien er th	To Be Co	c event, the	12				Hom	emaker				n Home	
pu	filed tal Hy od oth even			17. Father's Name (F	First, Middle, Last)					18. Mother's Nan	, ,	Maiden	Surname)	
Зa	Men Men narke			A. McCo					Mabel E					
Ja r	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Deborah Sanders Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 10124 Kings Bench Court; Ellicott City,											
e,	and 2		Deborah 20a. Method of Disp		Daugh			sition (Name of	inch Cour	Date	$\overline{}$	ocation - City or		
Baltimore, Maryland 21215-0036	ge 1 nt of t: if it		1 🗵 Burial 2	Cremation 3	Removal from State	ce	metery, crei	natory or other place			1	-	Maryland	
賣	iit. Pa irtme irtani injury		4 ☐ Conation 21. Signature of Fu	5 Other (Spec		Loud	ion Pa	rk Cemete	ery 1-/-					
Ba	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Fu	Service Licer	101234		Įį	2. Name and Addres uneral Ho 630 Edmor	me of Ca	tonsvil	le,	Inc Sville.	MD 21228	
		Н	23a, Part 1, Enter th		plications that cause	d the death						3,1110,	Approximate	
			shock, or hear Immediate Cause (F	t fåilure. List only	one cause on each lir	ie.						20	Interval Between Onset and Death	
	Pnysician/ ≱ Medical		disease or condition resulting in death)		a. Due to (or as	6 XIC	ence off:	ESPIRA	CORT	FAIL	_0,	<u> </u>	Lango	
	Examiner					NOS	arol	SPIRA	PNEUL	MONI	A			
		ner	Esquentium list con if any, leading to im cause. Enter Under	mediate	Due to (or as	a conseque	ence of):							
	be executed sician and burial-transit	Examiner	Cause (Disease or i	iinjury	C									
	executed an and irial-transi	alEy	resulting in death) L		Due to (or as	a conseque	ence of):							
4 09	The law requires that the death certificate be rate has been signed by the attending physici; page 2 should be detached for use as the bu				d									
68760	rtifica ing pl	₩.	IF FEMALE:		20 - 15									
Q X	th ce	ian,	23b. Was decedent in the past 12 r	nopths?	23c. If yes, outcome	2 🗌 Fetal	death 3	Ectopic pregnanc	у			23d. Date of de Month	elivery Day Year	
Box	e dea the a hed fi	ysic	1 Yes & D	No	4 🗌 Pregnant 9 🔲 Unknown		eam St	Other (specify)						
, P.O.	sician: The law requires that the death certificate t certificate has been signed by the attending phys rector, page 2 should be detached for use as the	by Physician/Medic	Part II. Other signifi	icant conditions	contributing to death	but not resu	ılting in the	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?	
	signe d be									1 🗆	Yes 🦂	2 √No 3 □ F	Probably 4 Unknown	
E Cord	requi been shoul	lete								24a. Was	an	24b. Were au	utopsy findings available	
MER Records,	e law e has ge 2	Completed								perf	opsy ormed?	death?	completion of cause of	
Z K	n: Th ificate or, pa	ပ္ခဲ့	25. Was case referre	ed to medical	T			26. Pla	ace of Death (Che	1 Yes	201	No 1 Te	s 2 No	
∑ Jal	s cert	To Be	examiner?	No	Hospital:	tient 2 🗆 I	EB/Outpatie	nt 3 DOA Othe	ar.		idence	6 ☐ Other (Spec	cify)	
トレップ Division of Vital	g Phy er this eral o		27. Manner of Death	_	28a. Date of inj	ury	28b. Time o injury		at	28d. Describe				
7 6	ath. r: Aft	Certificate:	1 Natural 2 Accident	5 Pending Investigation	on	ay, rear)	піјагу		Yes 2 No					
isi	er de recto by th	i.	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	28e. Place of In	jury - At hor tc. (Specify)		eet, factory, office		28f. Location City or To			ural Route Number,	
Ω̈́	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,			/									·-·	
	Hosp 4 hou Funer	Medical	(Check 2	Medical Exar	ysician: To the best on the basis of	examination	and/or inves	stigation, in my opinio	n, death occurred	at the time, date	and place	ce, and due to the	cause(s) and manner stated.	
only one) 3 Certifying Nurse Practioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and m														
	6 .≱68		Signature and	h Aer	any	M	D		-638	0	29u. D	12/1	1 / 1 1	
	I am		on No	0	completed cause of	death /Itam	23a) /Tima		-6-566	9			/ 11	
	J M		30. Name and addre		Completed cause of	900	(A	TON AV	AA A	L7/M	ORF	IM S	21229	
	Sta	te	31. Date filed (Monti	h, Day, Year)	1 2	rar's Signat			, , ,	(, , , ,			,	
	Registr		DI	C 1 5 20	11 12	. 9	130	Kee						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 13. 2011 DECEMBER EDITH KLEIN 12:13 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE N/AIf Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 THING A DX 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Days 08/07/1918 Director HUNGARY 295-07-7030 93 Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director 28a-f MD N/A 1 Yes 2 No BALTIMORE 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral with 23a 5909 KEY AVENUE 21215 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give Specify: 3 XWidowed 4 Divorced WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ HARTSTEIN WILLIAM SARA POLLAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Department of Health Important: If item 27 any injury or other the once. JAY KLEIN/SON 1824 E. 24TH STREET, BROOKLYN, NY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ XBurial 2 □ Cremation 3 X Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BETH DAVID CEMETERY 12/14/2011 ELMONT, NY Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death ATHEROSCLEROTIC Priysician/ CARDIOVASCULAR DISEASE disease or condition yeurs Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence or). burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as 1 IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires ANEMIA 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No DEMENTIA 24a. Was an has autopsy performed?

1 Yes 2 No RENAU PAILURE certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident М Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier D3037 December 13, 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORIE MO 21215 6503 PARIL HEIGHTS AME MV

△ DHMH 17 Rev 7/2009

State

Registrar

RUBERT

31. Date filed (Month, Day, Year)

NFC

M

1

5 2011

32. Registrar's Signature

COOPER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / 2 Day Year 9:45 A M Physician/ ROXIE ANN 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MARIS HOSPICE BAUTIMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 195-26-9979 **Director** 1 □ M 2 😿 F 82 Yrs. NC 1929 29 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director MD BAUTIMORE 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Funeral N. LINWOOD AVE items 23a 21213 USA 1322 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc ō by 1 Never Married 2 Married BLACK If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced 9:45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE SELF-EMPLOYED Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental His marked of မ SM ITH HATTIE WEBB TURNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau PARK DR. TINSON, MD. 21204 LEONARD LEE KENILWORTH JON 20c. Location - City or Town, State DECEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 H Removal from State North Hampton Co, N.C. SMITH + WEBB FAMILY CEMERY 12/18/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCVS Signature of Funeral Se vice License ROAD. BALTO, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ UTERINE CANCER disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examiner Due to (or switteen exclusion of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month 5 Other (specify) been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has h filled in by the funeral director, page 2 autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner?

1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

2

State

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

32. Registrar's Signat

MORGAN,

TRACIE L. 31. Date filed (Month, Day, Year)

			Please	Type or Print in B			_		egible.	
PM			ForState	State of Maryland		nt of Health and te of Death	Mental Hy		011	1,001,6
4			Registrar 1. Decedent's Name (First, Middle Das	st)	Certificat	e or beatin	2. Date of De	Reg. No. /	ULL	3. Time of Death
5	Physicia Medic			net Lunn			Month DEC	Day	Year 2011	9-35 PM
9	Examin		4a. Facility Name (if not natitution, give	Lrvington	4b. City	Town, or Location of Dear	th	4c. Co	unty of Death	
=	Funeral Director		5. Social Security Number 6. S		t birthday) If Under Months Yrs.	er 1 Year If Under 24 Hrs	(Month, Da	y, Year)	9. Birthp Coun	place (State or Foreign try)
1	A	_	Usual Residence of Decedent 10a, State 10b, County	71	Town or Location		3-6-	1932	- 1	0d. Inside City Limits
7	ne Marylar or 28a-f st notified	recto	MD	Bo	Utimora	ಲ				1 Yes 2 □ No
	21215-0036 within 72 hours after death with the Maryland giene. tr than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 2327 Edmon	dson Aveni	الول الول الول الول الول الول الول الول	21223			of What Cour	ntry?
5	death i items		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)		Race - Americ Black, White,	
- M	21215-0036 within 72 hours after dea giene. er than "natural", or iter er than "natural", or iter the Medical Examiner.	ed by	1 Never Married 2 Married 3 Widowed 4 Di Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1 🗆 Yes	2 No Specify:		Spe	ecify: Blo	ick
_	215-0 172 hour	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's Usi (Give kind of we Nife. DO NOT us	ork done during most of wo	orking		of Business/In	α
る			Elementary/Secondary (0-12)	College (1-4 or 5+)	Placem	1 (ilist.	^	imore	Lity
3	Iryland 2 ould be filed wi Id Mental Hygie marked other matic event, ti	To Be	17 Pather's Name (First, Mindle, Last)	lard		18. Mother's Na	ame (First, Middle) Tie, K	Maider Sun	rase)	
M	6 5 8 8		. Informant's Name/Relationship (1		19b. Mailing Address				vn, State, Zip (
्ठ	Te, l and f Heal item		Devereaux L 20a. Method of Disposition		ace of Disposition (Na	ame of	Date	00-1	City on T	MD 21216 own, State
7	Baltimore, permit. Page 1 and Department of Her Important: If item any injury or othe once.		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont	fy) K	pletery, crematory or	-K 12-	19-11	Wind	SON	II. MD
5	Ball permit Depar Impor any in		21. Signature of Funeral Service Licen	Freeze	23/4000 515/7	and Address of Facilities	ere tu	Leral	229)	ces
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	one cause on each line.			c or respiratory a	rrest,		Approximate Interval Between Onset and Death
4	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseque	-URE To	THRIVE			7	EW WEEKS
	Examiner	<u>_</u>	Sequentially list conditions,	b						
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V	e executed sian and nurial-transit	-	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
	760 icate be physic	ledic		d						
	x 68 h certifi tending or use a	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan	death 3 Ectopic	pregnancy		230	d. Date of delive	rery Day Year
	Bo re deat	nysici	in the past 12 months? 1 ☐ Yes 2 ☒ No g ☐ Unknown	4 Pregnant at time of de 9 Unknown	eath 5 Other (specify)			Worth	Day Toal
	ords, P.O. Box 68760 requires that the death certificate be been signed by the attending physici should be detached for use as the bu	by P	Part II. Other significant conditions	contributing to death but not result.				,		he cause of death?
	rds, require been si should	Completed	y ENILA	1/4, //1/4	STICKAL		24a. Was		24b. Were auto	psv findings available
	f Vital Recc Physician: The law this certificate has	Somp					auto	opsy ormed? 2. No	prior to co death? 1 Yes	ompletion of cause of 2 No
	ician:	To Be (25. Was case referred to medical examiner?	Hospital:		26. Place of Death (Ch				
	Division of Vital Records, P.O. Box 68760 at or Attending Physician: The law requires that the death certificate b is after death. Is infector. After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the key in the funeral director.	te: To	1 ☐ Yes 2 🕱 No 27. Manner of Death 1 💆 Natural 5 ☐ Pending	1 Inpatient 2 I 28a. Date of injury (Month, Day, Year)	ER/Outpatient 3 🔲 I 28b. Time of injury	DOA 4 2 Nursing 28c. Injury at work?	Home 5 Res 28d. Describe			<u>y)</u>
	sion ttendir death. stor: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not	De 28e Place of Injuny - At hor	M	1 Yes 2 No	28f. Location	(Street and N	umber or Rura	l Route Number,
	Divis	Cer	4 Homicide determined	building, etc. (Specify)			City or To	wn, State)		
	Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	ledical	(Check 2 Medical Exan	vician: To the best of my knowle niner: On the basis of examination are Practitioner: To the best of m	and/or investigation, i	n my opinion, death occurre	d at the time, date	and place, an	d due to the ca	ause(s) and manner stated.
	To the within To the comp	Σ	29b. Signature and title of certifier			9c. License number		29d. Date s	igned (Month,	Day, Year)
(٨,		30. Name and address of person who	MD completed cause of death (Item	23a) (Type, Print)	De 62634			12, 2	
	4		30. Name and address of person who	1 AUAN 10796	HICKYRY	RIDGE RO	COLUMI	SIA M.	0 2100	14
	Sta Registi		31. Date DEC 1. 5 2011	A Begistrack Signed	aver					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4 1 01	Maryland / Dep	partment of Healt	h and Me	ntal Hygie	ene		
		State Registrar	Ce	ertificate of Deat	h	Reg	1. No. 201	4004/	
Physici	an/	1. Decedent's Name (First, Middle, Last)	LATIC		2	Date of Death Month	Day Year	3. Time of Death / 0:52 A M	
Med Exami		RAYMOND ALFONSO] 4a. Facility Name (if not institution, give street and number,	LAWS	4b. City, Town, or Locati	ion of Death	12	4c. County of Dear		
		UNION MEMORIAL HOSPITAL		BALTIMORE			N/A		
Funera Director		T	Age (In yrs. last birthday)	If Under 1 Year If Un Months Days Hour		. Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)	
3		Usual Residence of Decedent	74 Yrs.		s	EPT. 5,	1937 SOU'	TH CAROLINA	
ryland -f sho	cto	10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits	
ne Mai or 28a notifi	Director	MARYLAND N/A 10e. Street and Number	<u>.</u>	B. 10f. Zip Code	ALTIMOR		a. Citizen of What Co	1 XXVes 2 No	
with ti	Funeral	595 S. BEECHFIELD AVENU	E	21229		100	U.S.A.	Surray :	
death items	Fun	11. Marital Status 12. Was Deceden Armed Forces	at Ever in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify	/ Yes or No- an, etc.)	14. Race - Ame Black, Whit		
)36 after al", or Exami	d by	1 Never Married 2 XXMarried 1 Yes 2 If Yes, Give Year or Dates,	X No	1 ☐ Yes 2 💢 No Spec		,	Specify:BLA		
21215-0036 within 72 hours after giene. her than "natural", o	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupation		16	b. Kind of Business	/Industry	
hin 72 ne. than "	mo	Elementary/Secondary (0-12) College (1-4 or	life 1	e kind of work done during n DO NOT use retired)	nost of working				
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at.	Be	10th grade 17. Father's Name (First, Middle, Last)		COOK	other's Name (F	irst, Middle, Mai	FOOD SE	RVICE	
Maryland 2 2 should be filed wi th and Mental Hygie 27 is marked other traumatic event, ti	은	JOHN LAWS			VA LAWS	nog migalo, ma	adir damand,		
ਲੀ ਸ਼ਾਲ		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street and Nur	mber or Rural R	oute Number, Ci	ty or Town, State, Zi	p Code)	
		Emma N. Laws/Wife 20a. Method of Disposition	595 20b. Place of Disp	S. Beechfie	1				
0		1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	te cemetery, cre	ematory or other place)	Date 12 17		c. Location - City or		
- 3565		21. Signature hard be Mod Linder		PARK CEMETER' 2. Name and Address of Fa					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
								Onset and Death	
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	less Elec	trical Acti	vity			4 hours	
CALL STREET, SALES		disease or condition resulting in death) a. Due to (or a	s a consequence of):	ctrical Acti	vity			1 month	
Medical Examiner		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	s a consequence of): Cordity s a consequence of).	ctrical Acti	vity			1 month	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate: To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregrent in the past 12 months? 1	is a consequence of): Coodify is a consequence of): is a conseque	26. Place of Eart 3 DOA Other: 28c. Injury at work? M 28c. Injury at work? M 28c. Injury at work? Occurred at the time, date a stigation, in my opinion, death a, death occurred at the time, 29c. License number ATZY	Part I. Death (Check on 28c) Nursing Home 28c Death No 28f and place, and chocurred at the death of the courred at the date and place, date and place, date and place.	1 Yes 24a. Was an autopsy performe 1 Yes 2 If yone) 5 Residence 1. Describe how to the cause of time, date and pand due to the cause and due to the cause.	Month 2 No 3 P 24b. Were au prior to death? 1 Yes e 6 Other (Specinjury occurred) t and Number or Rutate) (s) and manner as stace, and due to the ause(s) and manner as	2 menth Itivery Day Year The cause of death? The bably 4 Unknown Intopsy findings available completion of cause of s 2 No The cause of death? The bably 4 Unknown The course of death? The cause of death? The cau	
The law requires that the death certificate be executed The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical Certificate: To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregrent in the past 12 months? 1	is a consequence of): Coodiffs is a consequence of): is a consequ	□ Ectopic pregnancy □ Other (specify) underlying cause given in Potent 3 □ DOA Other: 4 □ Other: M 1 □ Yes 2 reet, factory, office occurred at the time, date a stigation, in my opinion, death e, death occurred at the time, 29c. License number ATZ4 Print)	Part I. Death (Check on 28c) Nursing Home 28c Death No 28f and place, and chocurred at the death of the courred at the date and place, date and place, date and place.	1 Yes 24a. Was an autopsy performe 1 Yes 2 If yone) 5 Residence 1. Describe how to the cause of time, date and pand due to the cause and due to the cause.	Month 2 No 3 P 24b. Were au prior to death? 1 Yes e 6 Other (Specinjury occurred) t and Number or Rutate) (s) and manner as stace, and due to the ause(s) and manner as	2 menth Itivery Day Year The cause of death? The bably 4 Unknown Intopsy findings available completion of cause of s 2 No The cause of death? The bably 4 Unknown The course of death? The cause of death? The cau	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 20 Certificate of Death 3. Time of Death In Co edent's Name (First, Middle Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Fords Lane Baltimore 9. Birthplace (State or Foreign 24 Hrs. Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Hours Director 1 **X**M 2 □ F -28-1953 58 VA 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director 1 XYes 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21215 USA Fords 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Medical Examiner Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 9 þ filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Black "natural" Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Disabled Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or etc. Lofton 2 Viola Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimoie, MD Goodwood Ave. James 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State crematory or 11/29/2011 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sew e Licensee March F/H East 1101 E. North Scamf Muller MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause an each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi). Examir attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Dunknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one Be Other: 1 Yes _2 🗶 No ဂ္ 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Sig

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 40049 Certificate of Death 1 Decedent's Name (First Middle | ast 2. Date of Death 3. Time of Death Month 12 Physician/ 2011 1 4:07 P Fonne A. LaBorde Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Gilchrist Hospice Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs, 8. Date of Birth 6. Sex **Funeral** (Month, Day, Year) 204-14-1437 Director 1 X M 2 🗆 F 89 10-12-1922 Pennsylvania Usual Residence of Deced 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Examiner must be notified at Funeral Director 1 X Yes 2 No PA Cameron Emporium 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 598 Sizerville Road 15834 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 🕱 Yes 2 🗌 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: Specify: 3 Widowed 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Automobile Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Orvin LaBorde Katherine Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emporium, PA 15834 598 Sizerville Road Enes LaBorde (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Rockton Cemetery 12-17-2011 Rockton, PA 22. Name and Address of Facility Witzke Funeral Homes, Signature of Funeral Servi 52010r Columbia, MD 21045 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Complications WPOLE disease or condition Medical resulting in death) r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events nding physician and use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by myeloma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? heart 24a. Was an page 2 s performed 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS Pice Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending Investigation Accident 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

CEDAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

105ERH

5 2011

31. Date filed (Month, Day, Year)

DFC.

336

32. Registrar's Sig

D0060634

COLUMBIA

ANE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40050 State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}, 2011 December 8:43 a M WILLIAM SHIRLEY McCLELLAND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital Olney . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (Iri vrs. last birthday) Month Day, Year) 19 18, 1933 Months Days Hours Min. 1**X**XM 2 □ F 214-30-0210 78 Director Aug MD Usual Residence of Decedent 28a-f show or items 23a or 28a-f sho miner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 XXNo Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15410 Bond Mill Road 20707 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 244 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black White etc. 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2XXNo Specify Specify: "natural", 3 Widowed 4XXDivorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Retail Elementary/Seconday (0-12) College (1-4 or 5+) Grade 12 Shipping/Receiving Agent (Montgomery Wards) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Harry McClelland Ida Burton Department of Health and Important: If item 27 is n any injury or other traumone. and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15500 Bond Mill Road Laurel, Maryland 20707 Mary C. Carter daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State W. Arundel Crematory 12/9/2011 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Euneral Service Licensee Bonardscherfineral Home, P.A. / M00770 313 Talbott Avenue 20707 Laurel, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) min 21/ato Medical Due to or as a onsequence of) neemonis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an the Hospital or Attending Physician: The law In 24 hours after death.

the Funeral Director: After this certificate has k page 2 autopsy performed? death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Med B. 10050410 Dept EM mi

State Registrar rince

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

what

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year 22:27 M Mc Crimmon 12 Gregory Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Maryland medical Center.
5. Social Security Number 6. Sex 17. Age (In vrs. 1 Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 212-50-3105 **Director** 65 1X M 2 □ F 10-23-1946 and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral be filed within 72 hours after death with 21207 USA 6811 Campfield Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: Specify: African-American 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ Seagram's Distillery Pipefitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leo McCrimmon Ruth Elerbee injury or other traumatic 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print)
Gregory Thomas McCrinmon/ Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings Mills, Mid 21117 Drive Baltimore, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Owings Mills, MD 4 ☐ Donation 15 ☐ Other (Specify) 12/21/2011 | CWINGS MILLS, MD Garrison Forest Veterans 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Provincian COPD exacerbation disease or condition Medical resulting in death) **Examiner** malignanci metacratic Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events consuduence of physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death signed by the a 2 No 1 Yes 2 L ... Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has the funeral director, page 2 autopsy 1 Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined To the Hospital o within 24 hours af To the Funeral Di completely filled i Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 12/11 NPI# 1558651331 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 S. Greene Street Todd levi Baltimore an, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) Betty Lou Miller 2. Date of Death 3. Time of Death Physician/ Month PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ARNES HOSPITA ALTIMORE Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 **X** F Months Days Hours Min 0670571940 71 VA Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 820 South Caton Ave Apt 6I 21229 USA permit, Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Fleming Findley Myrtle Irene Widener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 Fords Lane Apt 508 Baltimore MD 21215 Terry L. Wilt Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crem 1 Burial 2 KCremation 3 Removal from State 12/14/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) IseHemic Medical Due to (or as a consequence of) Examiner YPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical MILLERA シミエエリ 甘り Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform After this certificate 1 Tes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No ☐ Accident after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 643E 20011 CEMBER 30. Mappe and address of person who completed cause of death (Item 23a) (Type, Print) BATEL mi CATON BALTIMORB HINTAN State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 13, 2011 Year 2:25 AM Harry G. Newcomer, Jr. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** Baltimore Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours July 14, 1929 Mary land 217-24-1616 82 1 ₺ M 2 □ F **Director** 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ Director Harford Examiner must be notified 28a-f 1 Yes 2X No Maryland White Hall 10e. Street and Numbe 10f Zip Code 10g. Citizen of What Country? or 23a 4532 Norrisville Road 21161 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XIX No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black White, etc. þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2XXNo Specify: 3 Widowed 4 Divorced Completed 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Greenspring Dairy 10 Foreman Milk Processing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ည Mary Glinda Mumaw Harry G. Newcomer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4532 Norrisville, Road, White Hall, Maryland 21161 Blanche Newcomer 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/14/2011 Glen Burnie, Maryland 2. Name and Address of Facility
Burgee Henss — Seitz Funeral Home
3631 Falls Road Balto, MD 212 21. Signature of Funeral Service Ucens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death .Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause (Disease or injury bus to for as a consequence of, requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician at s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death the Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform the Hospital or Attending Physician: The 1 ☐ Yes 2 🕒 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No ER/Outpatient 3 DOA မ 1 🗌 Inpatient 2 🗌 4 Nursing Home 5 Residence & Other (Specify) 24 hours after death.

Funeral Director: After this of 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check he cause(s) and marine 29d. Date signed (Month, Day, Year) 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chances 6701 31. Date filed (Month, Day, Year)

H DHMH 17 Rev 06-2011

Registrar

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 N For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ :450 M Phyllis M. Ordiway Dec 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Middle River Baltimore Ivy Hall Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 21,1928 9. Birthplace (State or Foreign Social Security Number . Age (In vrs. last birthday) **Funeral** Country) 216-42-0383 PA **Director** 1 □ M 2 🛛 F 83 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10a. State 10c. City, Town or Local notified at Director Middle River MD Baltimore 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō ms 23a or must be n 21220 USA Funeral 13211 Eastern Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. er than "natural", or ite Armed Forces?

1 Yes 2 No Black White etc 1 Never Married 2 Married þ Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) oe filed with.. ⁴al Hygiene. ⊶r than "r Elementary/Secondary (0-12) College (1-4 or 5+) Ivy Hall Nursing Aid 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h Josephine Wagon 2 Department of Health and Mont Important: If item 27 is marked any injury or con-Clyde L. James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13211 Eastern Avenue Baltimore MD 212 Sandra Zlotkowski/daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Taftsville Cemetery 5/1/12 Woodstock VT 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 300 Mace Ave. Balto Connelly Funeral Home of Essex 22. Name and Address of Facility Balto. MD Ssex 2122 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death 105 Lastoma Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 € 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No After this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier D61907 ONathe and address of person who completed cause of death (Item 23a) (Type, Print)

NACE AVENUE, BULLIMOR MOZIZZI

State Registrar 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 40055 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Phipp S Month Elsie 5:25 P De cember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** County of Death anda eason 405 Dice STOWN Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 134-30-8909 **Director** 1 □ M 2 🗹 70 28a-f show 10c. City, Town or Location be filed within 72 hours after death with the Maryland must be notified at 10b. County 10d. Inside City Limits Director 1 Yes 2 No ore 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code Funeral items 23a Gas 21207 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. ō <u>Ş</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No "natural", Completed 3 Divorced 4 Divorced ac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) To Be 17. Father's Name (First, Middle, Last) Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. aro Informant's Name/Relationship (Type, Print) te Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural 6807 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name Part 1. Enjet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician ENd-Stage Cardionyopath. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (of as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown 1 Tes been signification because the second Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed **Director:** After this certificate I d in by the funeral director, pag 1 🗌 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: 6 Dother (Specify) hospice 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated MS Ray upaneM.D 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057465 12/14/11

Registrar
DHMH 17 Rev 06-2011

State

Bathmore

MD 21709

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith

apakse M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 10:40 AM **Physician** DECEMBER OROTHY PETERS 13 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) July 27,1925 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 219-16-6635 86 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code should be filed within 72 hours after death with 1 nd Mental Hygiene. marked other than "natural", or items 23a or 3 2951 Cornwall Road 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian 11. Marital Status Black, White, etc. Yes 2 No Yes, Give 0 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White à 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi Walter C. Patrick Sr. Helen Lorenz Jore, Mc.

Jorenti. Pages 1 and 2 sho.
Department of Health and Important: if item 27 any Injury or 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2951 Cornwall Road, Dundalk, Maryland Dorothy Peters Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ganrison Forest VA. Cemetery 20, 2011 Owings Mills, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line Immediate Cause (Final **Physician** ardiopulmonam tows disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pneumotosis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 PNo 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation Injury 1 Yes 2 No 2 Accident Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 December 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 -nostopher 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40057 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Barry Wallace Poole December 6:51P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7912 Rustling Bark Court Ellicott City Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs . Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 158-34-9685 Director 1 🗷 M 2 🗆 F June 29, 1946 65 New Jersey "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City Howard 1 Yes 2xxNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral be filed within 72 hours after death with 7912 Rustling Bark Court 21042 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates nt of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food & Drug Administration Manager/Pharmacist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Allen Poole Anna Mary Bell and h 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 s ment of Health a tant: If item 27 i Robert Poole 7701 Chatfield Lane Ellicott City, Maryland 21043 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12-14-2011 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Maryland 21. Signature of Funeral Selvice License 22. Name and Address of Facility Witzke Funeral Homes, Inc. MOIDSV K. Hac 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ignan disease or condition MINI Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burnal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 4 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation ☐ Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License numbe

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death Physician/ Dav Year 08135AM 12 Medical 201 4c. Coupty of Death **Examiner** 7. Age (In vns. last birthday 8. Date of Birth 9. Birthplace (State or Foleign **Funeral Director** ems 23a or 28a-f show r must be notified at show by Funeral Director 1 Yes 2 No 10g. Citizen of What 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black 1 Never Married 2 Married ö 1 Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1 Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working life, BO NOT usg retired). (Specify only highest grade completed) Il Hygiene. Elementary/S condary (0-12) College (1-4 or 5+) the Be and Mental Fishers is marked o ပ it of Health a Baltimore, Method of Disposition Burial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or once. 4 Donation 5 Other (Specify) re of Funeral Service Licensee Inter the disease, or complications that caused the death. Do not enter Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Infarction Physician/ Myocardial disease or condition one. Medical resulting in death) Due to (or as a consequence of) **Examiner** 5-quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) as the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ been signed by the atter should be detached for in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 💆 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Tes Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X** No မ 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending work? 1 X Natural Pending injury 2 No Accident Suicide Investigation 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

University Parkway.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

East

12/12/2011

Baltimore, MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 12 Physician/ 07 2:58A M 2011 Doris Ninna Paye Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 039-66-0043 58 Director Yrs Sep. 15,1953 Liberia Usual Residence of Decede 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 XYes 2 No Providence RT Providence 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? Funeral USA 02907 94 Comstock Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. o 1 X Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Black. Specify: "natural". 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) Immigration Officer 12 Be permit. Page 1 and 2 should be fileo Department of Health and Mental Hy, Important: If item 27 is mark-any injury or other—once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Gbarway Gonseh Nyonton Paye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94 Comstock Avenue, Providence, RI Clarence Paye - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 01-07-2012 Cranston, RI Oakland Cemetery 4 Donation 5 Other (Specify) Bell Funeral Home, Inc. 22. Name and Address of Facility Signature of Funeral Service Licer 571 Broad Street, Providence, RI M01284 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Opset and Death
Unknown Immediate Cause (Final Physician/ a Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner quentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 No 11 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No After this certificate has death?
1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I DOA ျ 1 Yes 2 3 No filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending X Natural Accident Suicide Investigation
6 Could not be after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse, Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only on 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier . Signat 12/7/2011 D04359 ss of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Dr., Silver Spring, MD Raymond White, MD

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 - State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3. Time of Death Month Physician/ rowell 6:00A M December 1105 lames Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A season's Hospice Baltimore 5. Social Security Number 217-38-9011 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min Hours **Director** 1 **X**M 2 □ F Yrs 12/15/1939 Maryland 71 28a-f show 10d. Inside City Limits 10b. County aţ 10a. State 10c, City, Town or Location Director notified 1 Yes 2 No N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö items 23a or ner must be n Funeral U.S.A. 1701 N. Eutaw Place Apt 501 · death v Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates "natural", or by Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Baltimore City Sanitation Worker 10th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Rogers James Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health an
Important: If item 27 is u 18 N. Ellamont St., Baltimore, MD 21229 Priscilla McCaw(sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12/19/11 Owings Mills, MD 4 Donation 5 Other (Specify) Garrison Forest Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2 21. Signature of Funeral Service Licensee MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Laryngeal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) the g Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of ulmonar 24a. Was an has autopsy page 2 performed? death? Yes 2 Wo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other:
4 Nursing Home 5 Residence 6 Wother (Specify) The spice 2 HNo 1 🗌 Yes ER/Outpatient 3 DOA ည 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural Natural
Accident
Suicid iniury 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 [

State

DHMH 17 Rev 06-2011

Registrar

29b. Signature and title of b

31. Date filed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 5 2011

835

Registrar's Signature

29c. License number

Ste 203

00053337

Baltimore

29d, Date signed (Month, Day, Year)

11.2011

December

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 9:30 PM LAW Kamey 3 MANITA 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 208 CHESTNUT STREET BALTIMORE 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 234-38-6383 Director 1 □ M 2 🔀 F 85 Yrs WEST VIRGINIA 04-29-1926 or 28a-f shown notified at 10a. State with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD BATIMORE 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral "natural", or items 23a edical Examiner must b STREET CHESTNUT 21222 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify BLACK Specify: Completed 3 ₩ Widowed 4 □ Divorced is marked other than "natu aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) TIFFANY EAST CHEF 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EVLAH PATTERSON Haron LAW Spanita 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REED (DAUGHTER) Department of Health Important: If item 27 any injury or other the once. HANGTTA 5212 BORDAUX COVE. Ellicott City, MD. 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 12/19/11 BATTIMORE, MO 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS CEMETERY 22. Name and Address of Facility VAUGHN GREENE FUNDLAL SCVS P.A. 21. Signature of Funeral Service Licensee ROAD. BALTIMORE, MD. 21212 m0155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner the burial-transi Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? ģ Division of Vital Records, 1 Nes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 2 No Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to predica To Be 26. Place of Death (Check only one) 2 No Other 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA hours after death. Ineral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of a 29d. Date signed (Month, Day, Year) 114 0-41399 who completed cause of death (Item 23a) (Type, Print) Name and address of person North Port Klud New don 1005 31. Date filed (Month, Day, Year) State Registrar

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Ε.			Registrar 1. Decedent's Name (First, Middle, Last)			007	incate of E	- Catir	2. Date of	Reg. I	No.		3. Time of Death
п	Physicia Medic		Christine	G.	Reed Dec					mber	Day 2	Year	8:34 PM
Ö	Examir		4a. Facility Name (if not institution, give street Union Memorial Hospi				4b. City, Town, or Balti	Location o		4	4c. County	of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 4 - 40 - 2223 1 □ M		Age (In yrs. last birthday) 69 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.					f Birth n, Day, Year ry 17,	1942	9. Birth Cour Mary	place (State or Foreign ntry) yland
	and show	o	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Location							T	10d. Inside City Limits
	Maryli 28a-f otifiec	irect	Maryland Baltimore	:	Dundalk						1 □ Yes 2 X N		
	with the 23a or ust be n	Funeral Director	10e. Street and Number 6910 Ridgeway Road		10f. Zip Code 21222						Citizen of W	hat Cou	ntry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ Ω	1 Never Married 2 Married	Vas Decedent Burmed Forces? Yes 2 Yes, Give Year or Dates.	_	1	Vas Decedent of Hi f Yes, specify Cuba		gin? (Specify Yes or n, Puerto Rican, etc.	No-)		e - Amerio k, White, Whi	
Maryland 21215-0036	in 72 hou e. ian "natu Medical	Completed	15. Decedent's Educati (Specify only highest grade co		i+)	(Give I	lent's Usual Occupa kind of work done of ONOT use retired)	ation <i>furi</i> ng mosi	t of working	16b.	. Kind of Bu	siness/In	idustry
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yland	ld be file Mental H arked ot atic ever	To B	17. Father's Name (First, Middle, Last) Nelson Taylor						er's Name (First, Mic a Gradkow	en Surname,	,		
, Mar	id 2 shou salth and n 27 is m er traum:		19a. Informant's Name/Relationship (Type, Pi Charles K. Reed	^{int)} Husband	Ē			er or Rural Route Nu , Dundalk			tate, Zip 212		
Baltimore,	:. Page 1 ar tment of He tant: If iten jury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Remode 4 □ Donation 5 □ Other (Specify)	oval from State	cer	metery, cren	sition (Name of natory or other plac Cemetery		December 17, 2011	- 1	Location - ndalk,	•	
Bal	Depar Depar Impor any in		21. Signature of Funeral Service Licensee	SNA	10 0	W 22	Name and Address Connelly 1 110 Solle	s of Facilit Funer ers P	al Home Coint Road	f Dur	ndalk, ndalk,	P.A.	21222
ا د	h sician/ Medical		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	ons that caused se on each line		Do not ente		g, such as			, 		Approximate Interval Between Onset and Death Sdays
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			resulting in death) Last	Due to (or as	a conseque	nce of):							
68760	tificate ng ph) e as th	Med	IF FEMALE:										
Box 6	In the Prospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	in the past 12 months?	yes, outcome Live Birth Pregnant a Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	У		_	23d. Date Mor		very Day Year
P.O.	requires that the dec been signed by the s should be detached	by Pt	Part II. Other significant conditions contribu	iting to death b	ut not resul	ting in the u	nderlying cause giv	en in Part	I. 23e. i	Did tobacco	o use contri	bute to t	the cause of death?
ds,	quires en sig ould b	ted t								□ Yes	2 No	3 🗌 Pro	obably 4 🗆 Unknown
Records,	Ine law re- cate has be page 2 sho	Completed								Was an autopsy performed Yes 2	р	rior to co leath?	opsy findings available ompletion of cause of
al	ysician: The is certificate director, pag		25. Was case referred to medical examiner?				26. Pla	ace of Dea	th (Check only one)	res za	1001	L ies	2 🗆 140
of Vital	hysic this ce al dire	유	1 Yes 2 XNo	1 Anpati			nt 3 DOA Othe	4 ∟ Nt	ursing Home 5				у)
on of	ending Physath.	Certificate:	1 Natural 5 Pending 2 Accident Investigation	8a. Date of inju (Month, Day	ry 2 , Year)	8b. Time of injury	28c. Injury work M 1			ibe how inj	jury occurre	d	
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the '		4 - Homicide determined	building, etc	: (Specify)		eet, factory, office		City o	r Town, Sta	ite)		al Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: Consumption on the control of the c	n the basis of e	xamination a	and/or invest	igation, in my opinio death occurred at the	n, death od he time, da	ccurred at the time, o	late and pla	ce, and due	to the ca	ause(s) and manner stated.
	Z cor		29b. Signature and title of certifier	MD			29c. License		946	4	Date signed		
_	10 br.		30. Name and address of person who completely D. Lai Union	eted cause of d			Print) 201 E.	Unive	ursity Pkny	, Bal	timore	· M	3 2011 D 21218
	Star Registra	e	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	arked	,						

amend 28d per	ME g923 1/24/12amh Please T	ype or Print in Black Ir	ndelible Ink. Ensure A	III Copies Are Leg	gible.
	For State Registrar	State of Maryland / Depa	artment of Health and N tificate of Death	Mental Hygiene Reg. No. 2	011 10000
Physician/ Medical	DOLULIIV KAV			2. Date of Death	0 Year 3. Time of Death 12:25 pm
Examiner	4a. Facility Name (if not institution, give str Gilchrist Hospi		4b. City, Town, or Location of Death Towson	4c. Count Balti	y of Death More
Funeral Director	5 Social Security Number 228-24-1290 Usual Residence of Decedent	M 2 X F 83 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 3 (Manth. Page Sear)	9. Birthplace (State or Foreign VA
he Maryland or 28a-f shov s notified at Director	10a, State N/A	10c. City, Town or Lo Baltimore	cation		10d. Inside City Limits 1 Yes 2 No
leath with the items 23a or 2 er must be no Funeral Di	10e. Street and Number 3959 Wilsby Ave		10f. Zip Code 21218	10g Citizen of USA	What Country?
, F.B	1 Never Married 2 Married	Armed Forces?	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	Rican, etc.)	ce - American Indian, ck. White, etc. rican Amer.
Baltimore, Maryland 21215-0036 Dermit, Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyghent moortant: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam To Be Completed by		completed) (Give i	ent's Usual Occupation ind of work done during most of worki ONOT use retired) ing Tech. Emer	ng Sinai	Business/Industry Hospital
yland () Id be filed v Mental Hyg arked othe attic event,	Milton Scarborou	gh, Sr.	18. Mother's Name Ideal	e (First, Middle, Maiden Surnam Finney	ne)
Mar nd 2 shou ealth and m 27 is m	19a. Informant's Name/Relationship (Type, Leslie Dabney/Si	ster 195 Mailir 3959	g Address (Street and Number or Rura Wilsby Ave, Ba	LRoute Number, City or Town E	State, Zip Code)
imore Page 1 a ment of H tant: If ite	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Garrison	sition (Name of paton; or other place) forest V 12/2	Date 20c. Location Owings	- City or Town, State S Mills, MD
Balt permit. Depart Import any inj	21. Signature of Funeral Pervice Licenses	22 5	Name and Address of FacilitHar: 126 Belair Rd, I	i P. Close F Balt.,MD 212	.Svs,PA 06-5105
Physician/ Medical	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	cause on each line.	r the mode of dying, such as cardiac o		Approximate Interval Between Onset and Death
Examiner 5	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury	Directo (or as a nonsequence of)		1-4	
xecuted n and al-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		Ja James	
760 cate be e physicial s the burned edical	d.			An It	
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be executed thospital or Attending physician. The law requires that the death certificate be executed the start of the death of the start this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit edical Certificate: To Be Completed by Physician/Medical Exampedical Certificates.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	Ectopic pregnancy Other (specify)		ate of delivery onth Day Year
ords, P.O. Box requires that the death been signed by the atte should be detached for leted by Physicia	Part II. Other significant conditions contr	buting to death but not resulting in the u	nderlying cause given in Part		tribute to the cause of death?
fital Records, sician: The law require, certificate has been significator, page 2 should in Be Completed				autopsy performed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital hysician his certifi il director	25. Was case referred to medical examiner? 1 Ves 2 No	pital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death (Check	me 5 ☐ Residence 6 ☐ Oth	ner (Specify) Hospice
on of oding Pt of the the funeral cate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?	28d Describe how injury occur Multiple fall	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director, Medical Certificate: To Be (3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	August 8 2011 Wwkw. 28e. Place of Injury - A nome farm, strebuilding, etc. (Specify) 39 59 BATTMORE MD 21	et, factory, office Sisters House LISBY AVE	28f. Location (Street and Numb City or Town, State)	
To the Hospital within 24 hours and the Funeral I completely filled Medical	29a. Certifier 1 ertifying Physicia 2 Medical Examiner 2 ertifying June F	an: To the best of my knowledge, death of On the basis of examination and/or invest confidence To the best of Ty incomes.	gation, in my opinion, death occurred at	the time, date and place, and du	ue to the cause(s) and manner stated.
To i with	29b. Signature and title of certific	MD	29c. License number > 71040	29d. Date signe	ed (Month, Day, Year)
	30. Name and address of person who com	•	rint)	Datation	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	St Surtiz 4105	BALTIMORE	<u>M</u>)

Please Type or Print in Black Indelible link, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40064 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26 Physician/ Month Robertson 9:45 AM 2011 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 380 Berkshire Drive Riva Anne Arundel 5. Social Security Number 8. Date of Birth (Month, Pay, Sept 14 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 1 🗆 M 2 🖵 F North Carolina Director 85 Sept 245-24-9362 1926 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I item 27 is marked of uther than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland 1 🖾 Yes 2 🗆 No Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 380 Berkshire Drive 21140 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", 3 🕅 Widowed 4 🗌 Divorced If Yes, Give Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Payroll Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edna McKinnish Jerry Newton McKinney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 380 Berkshire Dr., Riva, MD 21140 Catherine Kuehn (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/1/2011 4 Donation 5 Other (Specify) Pisgah View Mem. Park Candler, NC 21. Signature of Funeral Service Licenses Groce Funeral Home & Cremation Service 1401 Patton Ave., Asheville, NC 28806 at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock or heart failure. List only one cause on each line. Approximate Interval Between Gastric Atony Immediate Cause (Final Phylician CANCER 04 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and I-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 C Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, has been signed to the second Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page death? certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pleatin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifyling Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Checl only one 29b. Signa 31. Date filed (Month, Day, Year) State 5 201 Registrar

DHMH 17 Rev 7/2009

11-09351 Lynne K. Stitle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		y, Town, or Location of Death Itimore	4c. County of Death N/A					
ineral rector	286-44-1043 1 M 2 X F 47 Yrs. Mc	Inder 1 Year If Under 24Hrs. 8. Date of on this Days Hours Min. 5/20	Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Ohio					
28a-f show any d at once. rector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location N/A	Baltimore City	10d. Inside City Limits 1 X Yes 2 No					
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saminer	3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 No specify: ual Occupation (Give kind of work done	specify: White 16b. Kind of Business/Industry					
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rked other	Roger Stitle	18.Mother's Name (First, Middle DOris	s, Maiden Surname) Schneider					
n 27 is ma numatic cy	Doris Stitle / Mother 4008 Ra	ess (Street and Number or Rural Route N in Dance, Sebring F						
Important: If iten 27 is marked other thinjury or other traumatic event, the Med Injury or Other traumatic event, the Med To Be COMI	4 Donation 5 Other Specify.	erve Crematory 12/1	20c. Location - City or Town, State 7/2011 Struthers, OH					
Injury	22 Signature of Funeral Service Licensee Victor P. Doda Charl 1501	and Address of Facility es L. Stevens Funera E. Fort Avenue, Bal	al Home, Inc. timore MD 21230					
ician dical niner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	de of dying, such as cardiac or respiratory	Approximate Interva Between Onset and Death					
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attending or use as	► 122h Mac decodest present in the		23d. Date of delivery Month Day Year					
deta	3		tobacco use contribute to the cause of death? Ves 2 No 3 Probably 4 Unknown					
certificate has been sig ector, page 2 should be Be Completed		1 ✓ Ye:	topsy prior to completion of cause of death?					
his certi director	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	26.Place of Death (Check only one) DOA Other Nursing Home 5	Residence 6 0ther:					
or: After the funeral		28c. Injury at Work? 28d. Describ	e how injury occurred					
Funeral Director: After the fulled in by the funeral Certification:	3 Suicide 6 Could not be determined (Specify)	n (Street and Number or Rural Route Number, City , State)						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 01124AM **Physician** LEN 13 DECEMBER TUCKER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year)
July 17, 1927 Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Maryland Months **Funeral** 1 🕅 M 2 🗆 F 84 220-22-2410 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 1 ☐ Yes 2 No ral", or items 23a or 28a-f sho Examiner must be notified at Dundalk Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number death with USA 21222 1931 Wareham Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite
Iry or other traumatic event, the Medical Examinar 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) SSA College (1-4 or 5+) Elementary/Secondary (0-12) Budget Analyst year 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Allen Chales Dallas Tucker 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1931 Wareham Road, Dundalk, Maryland wife Elvira Tucker permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Memorial December 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Middle River, Maryland 16, 2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licenses 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or is a consequence of): Immediate Cause (Final Hours **Physician** disease or condition resulting in death))/Medical Week **Examiner** Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): nding physician Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Year 1 🗌 Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DCA 1 ☐ Yes 2 ☐ No မ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 3 Suicide building, etc. (Specify) completely filled in by 4 🗌 Homicide 24 hours a Hospital 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ECEMBER 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Mostopher 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 5 2011 Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 40067 For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lillian Tracey Physician/ Month Day Medical December 7.30 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11406 Greenspring Avenue Lutherville **Baltimore** 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1 M 2 XX Days Months Hours Min. 212-20-7708 **Director** 89 April 26, 1922 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at ould be filed within 72 hours after death with the Maryland of Mental Hyglene. The William 1990 or items 23a or 28a-f showmarked other than "natural", or items 23a or 28a-f showmartic event, the Medical Examiner must be notified at mastic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Lutherville 1 Tes 2 TYNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11406 Greenspring Avenue 21093 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 WNo Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired)
School Teacher Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o 2 Owen Connelly Madelyn Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 George Tracey (Son) 5013 Sweet Air Road Baldwin, MD 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 permit. Page Department of Important: If any injury or once, Druid Ridge Cemetery 12/16/2011 Pikesville, MD 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final RESPIRATIONS Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ULMONIN Sequentially list conditions, Examine cause. Enter Underlying Due to (or as a consequence or) Cause (Disease or iinjury that initiated events as the burial-trar resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregn 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown to tne Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an Were autopsy findings available prior to completion of cause of autonsy perform 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) ည Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? __ Accident Investigation 1 Yes 2 🗌 No 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or illivesurg 3 Certifying Nurse Practioner: To the best of my knowledge d (Check only one at the time, data and place, and due to the 29b. Signatur and title of certifie 0002558 30. Name and address of person who completed cause of 8320 Bellong Ave Suite 120 Tough 21204 31. Date filed (Month, Day, Year) State

Registrar

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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)		er 1 Year	If Under :	24Hrs. 8 Min.	B. Date of B	irth(MM/DD/YY	(Y) 9. Birtl Cou	nplace (State or Foreign intry)
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Examiner	ij	failure. List only one caus Immediate Cause (Final diseas	Llamaina										Death
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Division of Vital Records, tal or Attending Physician: The law require an aber death. The Proceedings to be a proceeding the proceed the funeral director, page 2 should be in by the funeral director, page 2 should be	n: T	27. Manner of Death 1 Natural 5 Po	EOM8	te of Injury hth, Day,Year) D:	28b. Time o	f Injury		y at Work?	Is		e how injury occanged self	curred	
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o the lathin 2 or the longlet	Medical	one) 2 Medical Ex	aminer: On the basi and manne	s of examination	and/or investig	gation, in n	y opinion,	death occ	curred at t	the time, da	ite and place, ar	nd due to t	ne cause(s)
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_		30. Name and address of personal Allan, MD A	on who completed ca ssistant Medica			altimore	Street.	Baltimo	re, MD	21223			
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Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

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1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene, item 22 are treated at 27 is marked other than "natural", or items 23a or 28a-f si other traumatic event, the Medical Examiner must be notified. permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. Physician/ Medical **Examiner** sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed physician sthe burial the attending phone of the cate has been signed by the attendin page 2 should be detached for use After this certificate within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, t Certificate: Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my online, date occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License numbe 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Winifred Wall Month 120 pM Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUESTE HOSPITal Rosedale Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, OCT . 10 9. Birthplace (State or Foreign Country)
PA 1 □ M 2 🔀 F 90 Director 218-80-7698 Usual Residence of Decedent or 28a-f shov filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho items 23a or 28a-f sho ner must be notified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 N. Stuart Street 21221 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No 14. Race - American Indian, ò 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 1 Yes 2 No Specify: Specify: White injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Dry Cleaners 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve and Mental I ၉ Albert Jones Hazel Yeager 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1004 Gladway Road Baltimore MD 21220 Mischelle Fleischman 20a. Method of Disposition 20b. Place of Disposition (Name of Bayvaewat Cremateory 12/14/11 20c. Location - City or Town, State
Baltimore MD 1 🗆 Burial 2 🛮 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Þ Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypoxemia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Preumon ia Sequentially list conditions Examiner if any, leading to immediate

Cause (Disease or linjury Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director: After this of a pleted filled in by the funeral dir 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be 1 🗌 Yes 2 🗌 No Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Land Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I complet only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 037612

State Registrar

DHMH 17 Rev 7/2009

4000 FRANKLIN SQUARE OR Balto md Z1237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Mohamad
31. Date filed (Month, Day, Year)

Alabrash

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 9932 Lorraine Hagen Westerberg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UTIMORE 8. Date of Birth (Month, Day, Jan. 22 9. Birthplace (State or Foreign Country) 1919 North Dakota 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 472-18-4584 1 □ M 2 🖾 F Months Davs Hours Min. 92 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 No Catonsville MD Baltimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 21228 USA 709 Maiden Choice Lane RGS127 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home Economics Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Beatrice Page Sam Hagen 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6307 Frederick Road; Catonsville, MD 21228 Johanna Westerberg-Bagg 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 X Cremation 3 Removal from State 12/13/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. MO 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HOUR ACUTE MYOCARDIAL INPARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 HOUR HYPOXIC RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last executed OBSTRUCTIVE PULMONARY DISEASE attending physician Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be detached for a in the past 12 months?

1 Yes 2 No Day 9 Unknown PO. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ tonknown Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 25. Was case referred to medical 26_Place of Death (Check only one) Be examiner? Other: 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) o 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manni Certificate: 28d. Describe how injury occurred Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signeture and title of certifier 29c. License number 29d Date signed (Month, Day, Year) December 11, 2011 All May who completed cause of death (Item 23a) (Type, Print) and address of person 900 CATEN AUENCE BALTIMORE, MARYLAND 32. Plagistrar's Signature SHYDER 31. Date filed (Month, Day, Year) State

Registrar

		•	For State Registrar	State of Ivia	ryland / L	Certificate			icital Try	Reg. No.		
Ē	Physicia	in/	1. Decedent's Name (First, Middle, L		DSK				2. Date of De		Year	3. Time of Death
	Medic Examir	cal	4a. Facility Name (if not institution, gi	ve street and number)		4b. City, To	wn, or Loc	ation of Death	C	4c. County	of Death	100 10
wage i	Funeral Director				al //os In yrs. last birt. 88	hday) If Under 1		Um Q Under 24 Hrs. Durs Min.	8. Date of Bir (Month, Da 01/19/	v. Year)	9. Birthp Coun	place (State or Foreign try) NY
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr						1	0d. Inside City Limits
	the Mary or 28a-i oe notifie	I Direc	MD 10e. Street and Number	HOWARD		COLUMBIA 10f. Zip C	ode			10g. Citizen of		1 ☐ Yes 2 🔀 N
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	by Funeral Director	9562 ANGELINA 11. Marital Status	12. Was Decedent Every Armed Forces?	er in U.S.	13. Was Deceder If Yes, specify		21045 nic Origin? (Spe	ecify Yes or No-	14. Rac	USA e - Americ	
9036	irs after d ural", or i I Examin	ed by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates.	0	1 Yes 2				Specify	ck, White, WH	HITE
21215-0036	nin 72 hou ne. i han "natu e Medica	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			Decedent's Usual ((Give kind of work of life. DO NOT use re REALT(done dunn etired)	ı g most of workı	<i>in</i> g	16b. Kind of B	usiness/In AL ES	
	ould be filed within 73 nd Mental Hygiene. marked other than imatic event, the Me	To Be C	17. Father's Name <i>(First, Middl</i> e, Las ISAAC	BLEIBE	RG	REALIC		Mother's Nam	e (First, Middle,	Maiden Surnam BILL	e)	
=	2 should be file th and Mental 27 is marked c traumatic eve		19a. Informant's Name/Relationship DIANE SCHMALL	(Type, Print)	198	o. Mailing Address (S				er, City or Town, S		Code)
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1	Removal from State	20b. Place o cemete	f Disposition (Name ry, crematory or othe SRAEL MEI	of er place)		Date	20c. Location	- City or To	
Baltir	permit. P Departme Importar any injur once.		21. Signature Funeral Service Lice	_	DEIII 1	22. Name and	Address of	Facility SC RSTOWN	L LEVII	NSON & B	ROS.	
	Ph_sician/ Medical Examiner Examiner	Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a	confequence with consequence	t infection	tun	with	Seps	15	ase	Approximate Interval Between Onset and Death
Box 68760	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and trail director, page 2 should be detached for use as the burial-transit	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mosths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at g Unknown	🗆 Fetal deat	h 3					ate of delive	rery Day Year
s, P.O.	res that th signed by d be detad	d by Ph	Part II. Other significant condition	s contributing to death bu	t not resulting	in the underlying ca	use given i	n Part I.				he cause of d eath?
Division of Vital Records,	The law ate has page 2	Complete			·						Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available ompletion of cause of
Vital	ysician: The s certificate director, pag	To Be	25. Was case referred t edical examiner? 1 Yes 2 No	Hospital:	nt 2 🗆 ER/O	utpatient 3 🗆 DOA	Other:	of Death (Chec		idence 6 🗆 Ott	ner (Specif	y)
on of	d ing h. After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of injury (Month, Day,		Time of 28d injury M	c. Injury at work? 1 \(\sum \) Yes	2 🗌 No	28d. Describe	how injury occur	red	-
Divisio	al or Atte s after dea I Director ed in by th	Certificate:	3 Suicide 6 Could no 4 Homicide determin		y - At home, fa (Specify)	arm, street, factory,	office			(Street and Numb wn, State)	per or Rura	l Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death or To the Funeral Director; After this certific completely filled in by the funeral director,	Medical	(Check 2 Medical Ex	hysician: To the best of n aminer: On the basis of ex- lurse Practitioner: To the	amination and/ best of my kno	or investigation, in m wledge, d eath occur	y opinion, d red at the ti	eath occurred a me, date and pl	at the time, date lace, and due to	and place, and di the cause(s) and	ue to the ca manner as	ause(s) and manner sta stated.
	To the within 2 To the comple	_	29b. Signature and title of certifier	M		29c. I	License nui	30 6 4 1	1	29d. Date signed December 29d.	ed (Month,	Day, Year)
			30. Name and address of person will Kamesh Sc	bapalhi	ath (Item 23a) 201-	(Type, Print) Ba	cic i	River	mede	Road	Esse	Day, Year) (13 20 11 (M) 212
	Sta Registr		31. Date filed (Month, Day, Year)	011 37. Registrar	's Signature	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40073 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1118 AM 4a. Facility Name (if not institution, give street and number) SOU Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland med Ctr Baltimare UNIVORSITY of 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) **Director** 1 □ M 2 🕱 F NONE Feb 16,1977 China 34 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director MD Columbia 1 Yes 2 No Howard 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be 23a Funeral China 10799 Hickory Ridge Road 21044 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify. 'natural", 3 Divorced 4 Divorced Asian Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Factory Owner/Operator other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic s Li Zhang Jie Wang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10799 Hickory Ridge Road, Columbia, Maryland 21044 Ling Zhang - Aunt 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Buria 2 X XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 12-15-2011 Glen Burnie, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Rome at 21. Sign of uner Serv MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Bilateral Introcronial Homorphoop Medical resulting in death) Due to (or as a consequence of) Examiner 10 days Thrombocytopenio Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-tran Metastatic Chor 1 occici u cuo Due to (or as a consequence of) Physician/Medical death certificate be IF FEMALE: 23c. If yes eutcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Dav Year Pregnant at time of death 29 2011 P.O. by been signed be should be det Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical vision of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 1 Natural 5 \square Pending 1 Yes 2 No 1 24 hours after death the Funeral Director. A pletely filled in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined O Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 1871892240 12/9/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRITTNEY WILLIAMS, MD South Greene St. Baltimore, MD 21201 (Month, Day, Year)
DEC 1 5 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene
		1	State Registrar Certificate of Death Reg. No. 2014
	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pay Year
5-0	Medic Examin		4a. Facility Name (I not institution, give street and number) 4b. City, Town, or bocation of Death 4c. County of Death
2000			10/20 New Hampshire HVE 201 Sales Pring PW Vortgomes 9. Second Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth 9. Serial Security Number 9. Serial Security Number 9. Serial Security Number 1 Security Number
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) Months Days Hours Min. (Month Day Fig. 1) Age (In yrs. last birthday) Months Days Hours Min. (Month Day Fig. 1) Age (In yrs. last birthday) Properties of the first
	nd how at	. h	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Marylar 18a-fs ntified	recto	MD Montgomery Silver Spring MD 12 Yes 2 No
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral Director	10e. Street and Number 10120 New Hampshise Aup#209 20903 10g. Citizen of What Country?
	eath w	Fune	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
36	after d	۵	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify:
2-00	hours natura dical E	plete	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only hinhest grade completed) (Sive kind of work done during most of working
21215-0036	within 72 /giene. ner than '	Completed	Elementary/Seconday (0-12) College (1-4 or 5+) iffe. DO NOT use retired) NA
	filed w al Hygi d other went, t	Be	17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	ould be file d Mental I marked o	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City of Town, State Zip Code)
	and 2 shou Health and tem 27 is m		San OK You 10120 New Hampshew Ave# 209 Silver Spring MD 20903
ore,	ye 1 an t of He If item or othe	Ì	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemeter) crematory or other place) 20c. Location - City or Town, State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- }	1 Burial 25th Cremation 3 Hernoval from State 4 Donation 5 Other (Specify) 21. Signature of purpose Service Licenses 22. Name and Address of Facility Howard Service Licenses
Ä	Depar Important in any ir	- 2	Collected Vorzobulterilled. Wasselmo 20199
			23a. Part t. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, App oximate Interval Between Interval Between One-t and Death
đ	Medical		disease or condition resulting in death) a. Due t. (or as a copsequence of):
	Examiner	e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):
	uted d ansi	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events C. C
	te be executed nysician and ne burial-transi		resulting in death) Last Due to (or as a consequence of):
68760	certificate be nding physici use as the bu	ledic	d
x 68	requires that the death certificate been signed by the attending ph should be detached for use as th	Completed by Physician/Medical	FFMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery 1
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P.0	aw requires that the as been signed by the 2 should be detach	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
rds,	requires	eted	Myeslipidemia: 1
Division of Vital Records,	itcian; The law requi certificate has been rector, page 2 shoule	omp	autopsy prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
talF	ysician: T is certifical director, p	Be C	25. Was case referred to medical examiner?
of Vi	Physic rthis c rral dire	은	1 L Yes 2 L No 1 Inpatient 2 L ER/Outpatient 3 L DOA 4 Nursing Home 5 L Hesidence 6 L Other (Specify)
on o	Attending Physician: or death. sctor: After this certific by the funeral director,	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be
ivisi	or Att after d Direct	Certi	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ω	To the Hospital or Attent within 24 hours after deati To the Funeral Director: completed filled in by the	Medical	29a. Certifier (Check (
	To the H within 24 To the F complete	Me	only one) 2 In Medical Examiner: On the basis of examination and of infocused in the data of the cause (s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	FSFÖ		2 Wahan Cashed CANP RO65612 12.9.2011
6	,		30. Name and address of person who completed cause of death (Item 23a) (Type Print) Barbara Beuchert Male Madical Care 19735 Germantown Pat #30 Residents 287
	Sta	te	31. Date filed (Month), Day Year) 32. Register's Signature 32. Register's Signature
	Regist		NEC TO SOLL YORK

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day You Month Physician/ LOWIENCE Archer 17.25 M 2011 11 25 Medical 4b. City, Town, or Location of Death University of Maryland Medical Center 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltmore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 64 **Director** 214-48-1320 1**XX**M 2 □ F Hawaii 10/6/1947 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location Director notified MD Dorchester Hurlock 1 🗌 Yes 🛣 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ö Examiner must be items 23a Funeral USA 21643 4160 Whiteleyville Rd. death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status was becedent Ever in U.S.

Armed Forces?

1★★Yes 2 □ No 1966—

If Yes, Give

Year or Dates. 1970 If Yes, specify Cuban, Mexican, Puerto Rican, etc. or, þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 72 hours after 1 Yes 2XXNo Specify: "natural", 3 Widowed 4XXDivorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Department of Health and Montal Hygene.
Important: If item 27 is marked other than "na any injury or other traumatic event ***. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Service Fire Fighter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary Augusta Parkinson Whitman J. Archer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Perry Landing Ct. Annapolis, MD 21401 Daughter <u>Alicia Smollon</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 11/30/2011 Hurlock, MD Maryland Veterans Cem 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Foneral Service L Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Acterio venous Medical resulting in death) **Examiner** 4 hours Intraparenely mal Sequentially list conditions Examine in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Unknown Yes 2 No 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 ☐ Yes 2 ☑ No certificate Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) obet 154 855 3035 125/2011

State

Registrar
DHMH 17 Rev 06-2011

Registrar's Signatur

22 S. Greene St. Bathmire, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elizabeth J. Le 31. Date filed (Month, Day, Year)

NOV 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 06:51 PM 2011 Physician/ No∜ethber 22 Stephen Anthony Anastasi Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Gambrills Anné Arundel 1220 Nob Hill Drive Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) Director 1 🛛 M 2 □ F 217-72-1912 2/6/1955 Washington, DC ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Gambrills Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral USA 1220 Nob Hill Drive 21054 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Medical Examiner Black, White, etc. Armed Forces 1 Never Married 2 X Married ☐ Yes 2 🗶 No δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify White "natural", If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Self Employed Security the year of Health and Mental Hygitem 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marianne Jenkins Tony Anastasi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a 1220 Nob Hill Drive, Gambrills, Maryland 21054 Lori L. Anastasi/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò permit. Page Department Important: If any injury or Edgewater, MD 11/23/11 Kalas Crematory 21. Signatu / Juley Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home MD 21037 2973 Solomons Island Road, Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final SCHETNIKER Proviolan/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed funeral director, page 2 1 🗆 Yes 2 🗆 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Tes 2 1110 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 ☐ Yes 2 ☐ No s after death. Investigation 3 Suicide
4 Homicide 6 🗌 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours at To the Funeral D completely filled it Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 only one) 29b. Signature and title of certifier 41698

- 4×

DHMH 17 Rev 06-2011

Registrar

State

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31. Date filed (Month, Day, Year)

Annorou

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Re

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NOV 2 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 State of Maryland Personnell of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Allen barce November 2:20PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's FutureCare Pineview Clinton Months Days Hours Min. 8. Date of Birth May Months Days Hours Min. (Month, Day, Year) Social Security Number **Funeral** 6. Sex 7 Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 🗆 M 2 🍱 F Months **Director** DC 578-50-0377 76 Usual Residence of Deceden 28a-f show death with the Maryland 10a State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Camp Spring Prince George's Maryland 5 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 23a United States 20747 6805 Edgemere Drive items "natural", or item 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 A No Specify. 12 should be filed within 12 mand Mental Hyglene.
alth and Mental Hyglene.
A 27 is marked other than "natural" Specify 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Practical Nurse Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anne Finley Stanley Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 20748 George W. Allen - Husband 6805 Edgemere Drive Camp Spring, Md. 20a. Method of Disposition Date, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or o 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State Dec. 4 Donation 5 Other (Specify) 2011 Resurrection Clinton, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. John 1/ Benning Road NE Washington, DC 20019 l4001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Aspiration Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Preumonia Medical Due to for as a consequence of) Examiner sphagin Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to lor all a conse whice of physician and s the bunal-transit requires that the death certificate be executed Cause (Disease or iinjury Dementin that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 as the IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has page 2 autopsy certificate Yes 2 No 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, [or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check opty one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0053337 November 30 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Ste 203 2835 SM Avenue nro)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12:45 pm Isobel H. Anderson November 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Potomac Valley Nursing Home Rockville Montgomery If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months **Director** 140-12-2388 1 □ M 2 🕱 F 89 July 29, 1922 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits rector 1 X Yes 2 No Maryland Howard Clarksville Ö 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? iral", or items 23a oi Examiner must be Funeral 11812 Linden Chapel Road 21029 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 X Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Banker Banking and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jacob Walker Heist Isobel Adams 1 and 2 should be f Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21029 Department of Health a Important: If item 27 is any injury or other trau once. Charles W. Anderson - Son 11812 Linden Chapel Road. Clarksville. Maruland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 12/02/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses MOL Hines-Rinaldi Funeral Home 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia Years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burialor Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ģ in the past 12 months?
1 Yes 2 X No Day Month Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed' death? 1 ☐ Yes 2 🗶 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 🗓 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29h. Signature and the of certifie 29c. License numbe

State Registrar M.D., F.A.C.P.,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anurita Mandhiratta.

NOV 3 0 2011

31. Date filed (Month, Day, Year)

D38262

November 28. 2011

2401 Research Blvd., #330, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November November Physician/ 26 20I1 0530 Margaret Belle Aldridge Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 751 Muller Rd. Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Year) 1<u>928</u> 1 □ M 2 🔀 F Months Days Sept 24 MD Director 83 214-24-9786 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2X No Carroll Westminster MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 **Examiner must** USA 751 Muller Rd 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. o. 1 Never Married 2 X Married þ ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify "natural", 3 Widowed 4 Divorced White Completed Year or Dates d 2 should be filed within 72 hours alth and Mental Hygiene.
127 is marked other than "natura or traumatic event, the Medical E. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ S. Frank Harman Elsie Barnes 1 and 2 should bot Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 751 Muller Rd. Westminster, MD Cassandra Aldridge/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westminster Cemetery 11/29/11 Westminster, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facili Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Eller underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death in the past 12 months? Day Month Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed⁴ 1 🗌 Yes 2 🗌 No 25. Was case referred Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \) Aesidence \(6 \sum \) Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Aatural 5 Pending 1 ☐ Yes 2 🗗 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed gause of death (Item 23a) (Type, Prin

Registrar

State

31. Date filed (Month, Day, Year)

NOV 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40080 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bernadin ennino Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Severna Park Anne Arundel In Comfort Arms Assisted Living Social Security Numbe If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Min. 1 □ M 2**X** F Days Hours (Month, Day **Director** 577-48-0698 03/21/1936 Wasdhigton DC Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21037 1805 Shore Drive within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 White should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", If Yes Give 1 ☐ Yes 2 XNo Specify. 3 ₩ Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Teacher College (1-4 or 5+) Elementary/Seconday (0-12) Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

1da Butler Ida Max Schwartz and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805~Shore~Drive~Edgewater, MD~21037Kelly Saltzman Daughter If item 27 permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State Woodfield Cemetery 11/29/2011 Galesville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 12 Ridgely Ave Annapolis,MD 21401 22. Name and Address of Facility Sal Hardesty Funeral Home P.A. 23a. Part 1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? certificate Yes 2 No 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifies completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Tes 2 11/10 Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗖 Other (Specify) 🚹 🛴 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 0 cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Mor

Baltimore,

Box 68760

P.O.

Records.

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Division

YLOR

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 1/22/2011 Physician/ Shirley Jean Bender 614am M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 218 Old Millbottom Rd Annapolis 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** Social Security Number Days 218-26-4450 79 Director 1 M 2XX 8/25/1932 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director must be notified 1 Yes XX No Annapolis Anne Arundel 10f. Zip Code o 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral USA 21409 218 Old Millbottom Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Examiner Black White etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event the Maximum. 1 Never Married 2 Married þ Yes 2xxNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify White 3 XXWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Fisher James Blaine Allston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23302 Pembrook DR. Hollywood, MD 20636 Michael Bender 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Margaret's Cem 11/28/2011 Annapolis, Md 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 Ridgely Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part 1. shock, or heart failure. List only one cause each line. Interval Between Onset and Death Immediate Cause (Final Physician/ accinorna IN 15. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burialnding physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Other (specify) Pregnant at time of death hed 9 Unknown g Unknown Hospital or Attending Physician: The law requires that the s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy 1 Yes 2 No certificate 1 Yes 2 director, 25. Was case referred to medical 26. Place of Death (Check only one Be Other: 4 Nursing Home Hospital ပ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral (28a. Date of injury (Month, Day, Year) Manper of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending iniury n 24 hours after death. e Funeral Director; Aft eletely filled in by the ful Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F one) 3 nature and till 29b. Sig 29c. License number 29d. Date signed (Month, Day, Year) 12239

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address

31. Date filed (Month, Day, Year)

NOV 2 9 2011

Medic.

Suite 210 DAM- gold MOZI40

completed cause of death (Item 23a) (Type, Print)

W

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 201 40082 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Edna Brown 3 . 10 A M November 24 26 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown North West Hospital 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 81 Director 195-26-0295 1 M 2 XX 5/26/1930 PA10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 1 Yes XX No MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21054 USA 994 Springhill Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XXVo If Yes, Give White 1 Yes 2XXNo Specify. ₩ Widowed 4 Divorced Specify. Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Mea Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Dively William Weyandt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 994 Springhill Way Gambrills, MD 21054 19a. Informant's Name/Relationship (Type, Print) 994 Springhill Way Barry Brown Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Cottontown, PA 4 Donation 5 Other (Specify) 11/30/2011 Claar Cemetery 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 21. Signature of Funeral Service Licensee 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Renal Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Be Completed by Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Jother (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nskyapane M. D 00057465 11/24/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajapakse, M.D. 283 S. Smith Av. S203 Baltimore MD 21209 N. S. Rajapakse, M.D

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40083 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year reay 4:307 D.S. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fairfield Nursing Home Crownsville Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Months 004-12-7740 94 Director Maine October 1 .1917 Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shor 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2583 Golfers Ridge Road 21401 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced WWII Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Foreign Service Officer Dept. of State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Peter Henry Boudreau Frances A. Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is Betty Jane Boudreau / Wife 2583 Golfers Ridge Road, Annapolis, Maryland 21401 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 11-25-2011 Edgewater, Maryland Signatur / Funny ervice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater. MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence) Examine 20 ension Sequentially list conditions, Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 1 ☐ Yes 2 ☐ Unknown detached 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 PNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ledical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Dav. Year) 25-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sate 1AHBORE 4ED MA 31. Date filed (Month, Day, Year) distrar's Signature State NOV 2 8 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 40084 Decedent's Name (First, Middle, Last) 2. Date of Death November 22, 2011 Physician/ William L. Brown 10:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3009 Tucker Road Fort Washington Prince George's Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min 08/25/1926 577-36-0256 Director 1 X M 2 D F 85 Pennsylvania Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10c City Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Marvland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 USA Tucker Road 3009 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ed other than "natural", or itelevent, the Medical Examiner Armed Forces?

1 X Yes 2 No Black White etc. þ 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Technician Telephone Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be f. Department of Health and Mental Important. If item 27 is marked any injury or other traumatic ev pe Norman A. Brown Elizabeth Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathryn Brown / Wife 3009 Tucker Road Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State Kalas Crematory 11/25/2011 Edgewater, Maryland 4 Donation 5 Other (Specify) Signature Fineral Service License 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Prostre disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 g 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2XXNo the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) 1 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending injury work? 2 🗌 No 2 Accident Investigation 24 hours after death Funeral Director: 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ဳ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 11-22-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN WETTZ 7525 Greenway CT Dr Greensett MD 20770 MARGIN WEHZ 31. Date filed (Month 32. Pegistrar's Signature State back

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 27, 2011 Physician/ Thelma Blue 15:20 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Clinton Prince George's Southern Maryland Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral Director** 213-30-6455 1 M 2 1 F March 9, 1933 South Carolina Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1045 Dorset Avenue 20602 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify: Yes. Give 3 Midowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Housekeeper 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Simpson Jackson Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Curtis Blue II - Son 1045 Dorset Drive Waldorf, Maryland or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Dec. ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lee's Crematory 2011 Clinton, Maryland 21. Signature of Funeral Service Licensee Q 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC P . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-t Due to (or as a consequence of): Physician/Medical that the death certificate be 68760 attending physical for use as the k IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending work?
1 Yes 2 No Natural injury 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours Medical 🌋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29c. License number 29d. Date signed (Month, Day, Year) D18545 November 30, 2011

Registrar

DHMH 17 Rev 06-2011

State

Print)

cause of death (Item 23a) (Type

32. Registrar's Signature

LINE CONTER WALDOUT LOCKOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40086 For For Registra AMFND#1perMD, 12/7/11; EMW, McCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 1 NAMED IN Allen Medical give street and number) 4c. County of Death Examiner Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min 225-37-0271 **Director** 26 1 **X** M 2 □ F July 9, 1985 Kentucky 28a-f show ms 23a or 28a-f shortman must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Prince William Manassas Park 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 9426 Rosebud Court 20111 or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. ed other than "natural", or iter event, the Medical Examiner Armed Forces? Black, White, etc þ 1 X Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Media Quality Control Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Donna Marie Reynolds Wayne Lewis Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne L. Baker / Father 9426 Rosebud Court Manassas Park, VA 20111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan 11/30/2011 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Found & Sons Lee Funeral Chapel MO1080 KW MISKO 8521 Sudley Road Manassas, VA 20109 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cerebral Herniahan Medical resulting in death) Due to (or as a consequence of Examiner Brain Tumar Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Medical certificate be Box 68760 as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown Division of Vital Records, 2 No 3 Probably Completed phode 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 2 L To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director, After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 21 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 2 🗆 No Investigation filled in by the t Accident Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie MD 30. Name and address of person who completed cause of death (Item Wan-Tsn Chang 31. Date filed (Month, Day, 2. Registrar's Sig State NOV 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1-	For State Registrar		State	of Marylan	-	rtment <i>tificate</i>				eg. No. 2	011	40087
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Med Exam	dical niner	4a.	Facility Name (if not in					4b. City, T	own, or Local lver	cation of Death	ng	4c. Cour Mor	nty of Death	ery
Funera Directo		5. 3	Social Security Number	r 6.	Sex 1 XM 2 ☐ F	7. Age (In yrs. la	ast birthday) Yrs.	If Under		Under 24 Hrs. Lours Min. 52	8. Date of Birth 1 (1/10/11/2 3/4)	2011	9. Birth Mar	place (State or Foreign Vland
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with the M 23a or 28 ist be not	eral Dir	10	e. Street and Number	eezew	ood Cc	urt #3	01	10f. Zip	Code 2077()		10g. Citizen c	of What Cou JSA	ntry?
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alla L	To Be C	17	. Father's Name (First,		,					3. Mother's Nam	e (First, Middle, I ia Zoz	Maiden Surna	me)	
Individual yidilik 2 should be file th and Mental H 27 is marked o		-	Pa. Informant's Name/F				19b. Mailin	g Address 8 Br	Street and	Number or Rura Wood C	al Route Number Ourt #3	City or Town	, State, Zip reenb	code 2077.0 elt,Md
age 1 and ent of Heal nt: If item 3		20	a. Method of Dispositi 1 Burial 2 CC 4 Donation 5	remation 3		a	Place of Dispos	sition (Name	e of per place)		Date 29/201	20c. Locatio	n - City or T	
permit. Page 1 Department of Important: If is any injury or or	ouce.	21	. Signatur Fur I	-71	In al	-						AL SĒ ver S	RVIC	E,P.A. g,Md20910
cate be executed Examine physician and street burial and street burial and	al	Ir d re	Ba. Part 1. Enter the di shock, or heaft fail mediate Cause (Final isease or condition sulting in death) equentially list condition any, leading to immediause. Enter Underlying ause (Disease or linjur lat initiated events ssulting in death) Last	ons, iate	a. Lue to	o (or as a consequence of or a consequence or a consequence of or a consequence or a consequence of or a consequence of or a consequence or a co	uence of): uence of):	n) Mr	del	iverel	nrespiratory arm			Approximate Interval Between Onset and Death
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The law requires ate has been signage 2 should b	Completed	-											prior to c	opsy findings available ompletion of cause of
nysician: hysician: lis certifica	To Be (25	. Was case referred to examiner?		Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 DC	Other:	e of Death <i>(Chec</i> 4 Nursing H	k only one) ome 5 🗆 Resid	ence 6 🗆 (
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Certificate:	27	2 Accident	Pending Investiga	ion	e of injury nth, Day, Year)	28b. Time of injury	M		s 2 🗆 No	28d. Describe h			
pital or At ours after of eral Direct	1		4 Homicide	determin	ed 28e. Plac buil	ee of Injury - At ho	y)			-tdl	City or Tow	n, State)		al Route Number,
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- s = ö		000	Name and address	of person with) mi)	n 23a) (Time =	Print)	00 66	148		11-	23-1	stated. Day, Year) MID 204J
	tate	31	. Date filed (Month, Da	ay, Year)	WV 32	Pegistrar's Signa	3V L	Jella	Nuel	var. Ste	320 5	ilva	Spri	mp 2095
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40088 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death n 18,2011 Physician/ Month 3:00р м Kathryn Bohac November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Renaissance Gardens - Riderwood Silver Spring If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Months washington, DC 578-24-1844 Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Tes 2 X No Silver Spring Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 20904 u.s.A. 3160 Gracefield Road, #3324 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò <u>ک</u> 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify. Specify. "natural" White Completed 3 X Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Department of Health and Mental Hygin Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Mamie Snyder Bruce Alley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 599 East Deer Creek Drive, Crossville, TN 38571 Bruce Blair - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery: 11/30/2011 21. Signature of Funeral Service Licen 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Congestive Heart Failure Unknown disease or condition Medical resulting in death) Due to (or as a consequence of) xaminer Unknown Hypertension Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last 1 <u>Arterioscler</u>otic Cardiovascular Disease Unknown and Due to (or as a consequence of attending physician I for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending newsieria P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal deat Pregnant at time of death 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus II 1 Yes 2 No 3 Probably 4 X Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Chronic Obstructive Pulmonary Disease 24a. Was an page 2 performed Yes 2 X No Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3160 Gracefield Road, Silver Spring, Maryland 20904 Eileen Gemmet, CRNP. Date filed (Month, Day, Year) State NOV 2 9 2011 Registrar

Please Type or Print in Black Indelinki Ensure All Copies Are Legible. For AMEND#19 aper FH, 127/11; BW, MCC Certificate of Death 40089 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20ar1 Day 3 Physician/ NOVEMBER 10:50A M BOATENG JOSEPH K Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In vrs. last birthday) 1 🗶 M 2 🗆 F Days (Month, Pay, Year) 40 Ghana Director 71 213-81-6840 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Funeral Director Frederick 1 Yes 2 No Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Ghana 21702 90 Waverley Drive, #L204 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify Black 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Associate 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Afosah Kwasi Boateng 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90 Waverley Drive. #L204. Frederick, MD 21702 <u>Agnes Boatend</u> Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Ukn 1 X Burial 2 Cremation 3 Removal from State 1/14/2011 Akumadan, Ghana Akumadan Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MOISIN 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Physician/ Fibrusis disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trapsit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No Be (25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0063498 11-13-11 WAN WADHWA, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 w 7th St Frederick, mD 21701 akhvinder Wadhwa 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2000

Registrar

NOV 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 6:15 am 201 Marvin Berkowitz November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Olney Montgomery General Hospital 9. Birthplace (State or Foreign Country) New York Date of Birth Social Security Number 6. Sex **Funeral** 1 **X** M 2 □ F Months Days Hours Month Pay / 1924 080-16-6246 Director 87 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20906 Leisure World Blvd., 3210 N. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Caucasian Completed 3 Widowed 4 Divorced WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education High School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Tillie Skoll Abraham Berkowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7520 Old Chester Road. Bethesda, Maryland 20817 Thea Mason - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Judean Memorial Grdns 11/25/2011 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Signature of Funeral Service Licenses M015764 MOON t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? for Month Dav Pregnant at time of death 2 No the a 9 Unknown g Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed Yes 2 2 🗌 No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending work? 2 No Accident Investigation within 24 hours after death

To the Funeral Director: A 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and litle of certifier

State

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Date filed (Month, Day, Year)

NOV 2 9 2011

Name and address of person who completed cause of death (Item 23a) (Type, Print

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	Snow Hill 5. Social Security Nun	nber	6. Sex	7.		last birthday)	If Unde	w Hil	If Under 2		8. Date of Bi	rth		9. Birthplace (State or Fore		ate or Foreig
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Completed by	Elementary/Secon		_	College (1-4	or 5+)	Ìife. Di	(Give kind of work done during most of working life. DO NOT use retired) mechanic						automotive			
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	23a. Part 1. Enter the shock, or heart	e disease, or failure. List o	complicati nly one ca	ons that cau	sed the dea line.	th. Do not ente	r the mod	le of dying	g, such as c	ardiac c	r respiratory a	rrest,			Approx Interva	imate I Between
	Immediate Cause (Findisease or condition resulting in death)	MER'	<u> </u>	DE.	MEN	TIA					Onset	and Death				
	,		Γ.	Due to (or	as a consec	quence of):										
lner	Sequentially list cond if any, leading to imm cause. Enter Underly	nediate ing	b	as a consec	s a consequence of):											
Examiner	Cause (Disease or iin that initiated events resulting in death) La	ijury	c. _	as a consec	a consequence of):											
<u>ica</u>	,															
Z F	IF FEMALE:												T			
Physician/Medical	23b. Was decedent pr in the past 12 mo 1 Yes 2 9 Unknown	onths?		lf yes, outco 1 ☐ Live Bir 4 ☐ Pregna 9 ☐ Unknov	th 2 🗀 Fet nt at time of	tal death 3 🗌	Ectopic Other (s	pregnancy pecify)	ý					ate of del	livery Day	Year
o y	Part II. Other signification	ant conditio	ns contrib	uting to deat	th but not re	sulting in the u	nderlying	cause giv	en in Part I.		23e. Did	tobacc	co use cor	ntribute to	the cause	of death?
g l											1 🗆	Yes	2 No	3 🗆 Pi	robably 4	4 🗍 Unknov
Completed											24a. Was	psy		prior to o		ngs availabl
	25. Was case referred	to modical									1 \(\text{Yes}	ormed 2	No.	death?	2 2 No)
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	27. Manner of Death	5 Pendin		8a. Date of		28b. Time of injury		28c. Injury work	at		28d. Describe					
	2 Accident Investigation 3 Suicide 6 Could not be						M et factor		Yes 2 1	-	28f. Location	Street	and Num	her or Ru	ral Route N	lumber
l Certificate:	4 Homicide	determi	ned		etc. (Specif		or, ractor	y, omice			City or To			ber or nur	arrionter	varriber,
Medical	(Check 2 ∟	Medicał E:	kaminer: (On the basis o	of examinatio	viedge, death o	gation, in	my opinio	n, death occ	curred at	the time, date	and pla	ace, and d	ue to the	cause(s) an	d manner st
	only one) 3 _ 29b. Signature and titl	Certifying	Nurse Pra	actioner: To	the best of m	ny knowledge, c	eath occu	rred at the	time, date a	and place	e, and due to t	he cau	se(s) and r	nanner as	stated. , Day, Yea	
		V	MU/	_				0 6					11		105	

State Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ShARAI) R SATYAL, MI) 1604 MARKET ST. POWMOKE GTY

31. Date filed (Month, Day, Year)

NOV 2 9 201 32. Registrar's Signature

Linear B. Jacks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40092 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lula Jean Bowers 2011 4:23 \mathbf{P}^{M} November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Country) **Funeral** (Month, Day, Hours Year 219-56-5748 1 □ M 2 🔽 F 60 Director Feb. Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director New Windsor 1 Yes 2 No MD Carroll 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code Funeral 21776 1703 Old New Windsor Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. White Yes 2 No Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏝 No Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carroll County Schools School Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eula Norris James Skeen, Sr. 19a. Informant's Name/Relationship (Type, Print) - Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 1703 Old New Windsor Rd., New Windsor, MD 21776 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 11/30/2011 1 🗆 Burial 2 🔀 Cremation 3 🗖 Removal from State Carroll Cremations Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Socie 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd., Westminster, MD 21157 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Physician/ disease or condition Medical resulting in death) Examiner 6m Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit Morbid and that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death g 🔲 Unknown Part II. <mark>Other significant conditions</mark> contrib*u*ting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State 31. Date filed (Month, Day, Year)
Registrar NOV 2

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30. Name and address of person who completed cause of death (Item_23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ November 27, 2011 1:10 a Roseanna R. Blacksten Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Golden Living Center Westminster Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Month, Day, 1 □ M 2 🛣 F Months Mary land ^{Year} 1922 89 Director 219-14-8112 Mar Usual Residence of Decedent shov 10d. Inside City Limits death with the Maryland must be notified at 10a, State 10b. County 10c. City, Town or Location Director Westminster 28a-f Maryland Carroll 1 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ò Completed by Funeral 23a 21157 USA 72 Madison Street ral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify. Specify: white "natural" 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Beauty Shop Beautician item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unknown Anna Irene Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 Chalet West, Millersville, MD 21108 Health attem 27 Joyce A. Golden, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of demetery, crematory or other place) Date 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2011 Manchester, MD Faiths Crematory 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Signature of Funeral Service Licensee art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exam me and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed?

1 Yes 2 No 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 8c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2, To the F complet only one) the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name

31. Date filed (Month, Day, Year)

NOV 28

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40094 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Brock, JR Russe11 11 4:00 A Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign '. Age (In yrs. last birthday) Funeral 1 🕅 M 2 🗆 F Days Months Wilmington, NC 239-36-9807 07/08/1930 Director 81 Usual Residence of Decedent than "natural", or items 23a or 28a-f show ne Medical Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director St. Mary's 1 Yes 2 No Mechanicsville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 20659 30006 Ronald Drive 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Pyes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Naval Oceanographic Offi¢e Navy 1 and 2 should be filed with Health and Mental Hyginitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Rogers Brock Thomas Russell Brock, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Margaret Ann Brock / Wife 30006 Ronald Drive Mechanicsville, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mary's Bryantown 12/2/2011 Bryantown, MD 22. Name and Address of Facility Brinsfield-Echols Funeral Home PA 21. Signature of Funeral Service Licensee Daryton cho Charlotte Hall, MD 20622 30195 Three Notch Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Interval Between
Onset and Death
3 Month shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician, Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury or Attending Physician; The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last by the attending physician Physician/Medical Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? within 24 hours after death. To the Funeral Director: After this certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical of Vital completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes Certificate: To inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending
__Investigation 1 Yes 2 No Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1. Secrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D54346 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHANDRA B. SATTA, 24035 THREE NOTCH ROAD, B. SAJJA, 6+1 eme MD 20636 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State DEC 0 2 2011

DHMH 17 Rev 7/2009

Registrar

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11-08900 Phillip Boing Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 40095

		1- For State Registrar	·	Cei	rtificate of	Death			- R	eg. No.		
Physici		1. Decedent's Name (First, Midd					•	2	2. Date of Dea Month		Year	3. Time of Death
dical Exami	ner		rles Bol						Month Novembe			1955 hrs
		4a. Facility Name (if not institution 21009 Aquasco Road		oer)	4	b. City, Town, or Aguasco	Location of	Death			ounty of Dea	
_	10	5. Social Security Number		Age (In yrs. la	aet hirthday)	If Under 1 Year	If Under	24Hrs	8 Date of Bir			irthplace (State or
Funeral Director		579-92-0487			•	Months Days	$\overline{}$	Min.			Fore	ign
	8	Usual Residence of Decedent	1 M 2 F	49	Yrs.				12/14/	1961		ountry)Florida
ku a		10a. State 10b. County		10c. City,	Town or Locati	on						10d. Inside City Limits
.	Ļ	MD Prince	e George's	Aa	uasco							1 Yes 2 No
ne Maryland or 28a-f show fied at once.	cto	10e. Street and Number	e dedige b	119	uabeo	10f. Zip Code			1	0g. Citizer	n of What Cou	untry?
ith the Maryland 23a or 28a-f sho notified at once.	Director	21009 Aquasco	Road			2060	8			US.	A	
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f she eat, the Medical Examiner must be notified at once	E	11. Marital Status	12. Was Deced			s Decedent of His				- 14		rican Indian, Black,
death or iter	Fune	1 Never Married 2 X M	Armed Force	es? 2 X No	If Ye	es, specify Cuban	, Mexican, I	Puerto R	lican, etc.)		White, etc.	
2 hours after d "natural", or	by F		vorced If Yes, Give Year or Dates:				specify:					nite
5-0036 led within 72 hours afterlygiene. other than "natural", the Medical Examination		15. Decedent's Education (Spe				s Usual Occupations of working life.				16b. Kind	d of Business	/Industry
36 thin 72 than	plet	Elementary/Secondary (0-12) 11	College (1-4	or 5+)	A	oile Par	t a		a tra		amah i	la Induator
5-0036 led within 7 Hygiene. l other than	Completed	17. Father's Name (First, Middle	Last)		Autoliloi				First, Middle, I			le Industry
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ages 1 and 2 should be fi and 2 should be fi and of Health and Mental tt: If item 27 is marked other traumatic event,	2	19a. Informant's Name/Relations			19b. Mailing	Address (Street	t and Numb	er or Ru	ral Route Nun			e, Zip Code)
MD 12 sho th and 127 is	- 1	Barbara Grimes	/ Mother-in			l Aquasco		d A	quasco		20608	
Heal Fitem		20a. Method of Disposition 1 V Burial 2 Cremation	a 2 Demoval from		Place of Disposi prematory or oth	tion (Name of cen	netery,		Date	20c. Loc	cation - City o	r Town, State
Pages ment or or oth	8 11	4 Donation 5 Other S	_		inity Me	emorial		12/1	/2011	Wa1	Ldorf,	MD
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		21. Signature of Funeral Service	Licensee									neral Home P
E E C B CO	- 12	/ Cler	rece -	00817								all, MD 2062
Physician /Medical		23a. Part 1 Enter the disease, or failure. List only one cause		sed the death.	Do not enter th	e mode of dying,	such as car	rdiac or r	espiratory arr	est, shock,	, or heart	Approximate Interval Between Onset end
<i>i</i> inedical		Immediate Cause (Final disease or condition resulting in death)				Hand						Death
,	Ę.		Due to (or as a co	onsequence of	1):							11 11
	둳	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of	f):							
	Examiner	(Disease or injury that initiated	c. Due to (or as a co		n.			_		_		
ited J ansit	Ä	events resulting in death) Last	d.	orisequence o	1).							
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED									
760, icate be physici the buri	Med	IF FEMALE:	23c. If yes, out	come of preg	nancy					23d, D	Date of delive	ry
687 ertific ding p		23b. Was decedent pregnant in the past 12 months?	1			al death 3	Ectopic	pregnan	су	Mo	onth	Day Year
Box 687 e death certific the attending of	/sician/	1 Yes 2 No 9 Un	known 9 Unknown	t at time of de	atn 5 Oth	ner (Specify)				T		
O. B. the de by the ched f	Phy	Part II. Other significant condit			esulting in the u	nderlying cause g	iven in Part	t I.	23e. Did to	obacco use	e contribute to	the cause of death?
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	ğ								1 Yes	2 🗸 N	No 3 Pro	bably 4 Unknown
ords, w requir s been s should t	Completed								24a. Was			utopsy findings available
e law e has l	g							-	autop	rmed?	death?	completion of cause of
ician: The scertificate rector, page		25. Was case referred to medica	1 [26 Place	of Death (C	heck on	1 Yes	2 No	1 🗸 Y	es 2 No
of Vital Records, of Physician: The law requirements certificate has been simeral director, page 2 should the	Be	examiner?	- Hospital:	atient 2	ER/Outpatient				Home 5	Residence	e 6 🗸 Othe	er: Scene
ding Phy	5	27. Manner of Death	28a. Date of	Injury	28b. Time of In		y at Work?	2	8d. Describe	now injury	осситеd	
Sion Attendin or death. rector: A by the fu	ertification:	1 Natural 5 Pen		51:1****	1853 hrs	1 □ Y	'es 2 🗸	No S	ubject sho	t by poli	ice	
Division tal or Attendi rs after death. al Director: A	2 €		stigation 28e. Place of	of Injury - At he	ome, farm, stree	t, factory, office be	uilding, etc.	. 2	8f. Location (S	Street and	Number or R	ural Route Number, City
	Cert	4 Homicide dete	and the second second	Residence				2	1009 Aquasi	co Road,	Aquasco, N	MD .
			hysician: To the best o									
To the Hospi within 24 hou To the Funct completely fi	Medical		aminer: On the basis of e	examination a ed	nd/or investigati			urred at t	the time, date			
	Σ	29b. Signature and title of certific	er /			29c. License						onth, Day, Year)
		J. W	IL			O.C.N	VI.E.			Noven	mber 27, 2	2011
),,,,,,		30. Name and address of person			•	Paltimore Stra	et Balti-	nore !	MD 21222			
)eme		Jack Titus MD. Dep	outy Chief Medical	trar's Signatu	104		et, Baitir	nore, r	VID 21223			
	ate	J. Date med (Work), Day, Year)	52, negis	an a dignatu		Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BURROUGHS 6:43 AM LISA November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) 579-62-6308 Director 1 🗆 M 2 🔀 F 51 Yrs. Aug. 6, 1960 Washington, DC Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d Inside City Limits 10a. State Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be a Funeral 771 Quince Orchard Blvd., #11 20878 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? African by 1 Never Married 2 X Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry Je filed with...
'at Hygiene.
'ar than "r (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Singer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charlie В. Burroughs, Sr. Lillie Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other Robert K. Allen, Sr. (Husband) 771 Quince Orchard Blvd., #11, Gaithersburg, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 12/02/2011 Waldorf. MD Heritage Memorial 22. Name and Address of Facility Jordan Funeral Service, Inc 4001 Benning Rd., N.E., Washington, DC 20019 21. Signature of Funeral Service Lic ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, or compare shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final cardiopulmonary disease or condition resulting in death) Due to (or as a co sequence of): 5 hock hypovolemic Sequentially list conditions, Examine that y, leading to in redicause. Enter Underlying acute anemin Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 🗷 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à atrial fibrillation, seizure, deep vein 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? thrombesis on anticoagulation 24a Was an autopsy performed? non stemi myocardial infarction, chronic anemia 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be

Physician/ Medical Examiner certificate be P.O. Box 68760

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altimore, Maryland 21215-0036

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attending physician for use as the buria ed by the a detached f signed by has certificate Il or Attending Physician: after death.
Director, After this certification funeral

Division of Vital Records,

1 Yes 2 No

Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify 1 Marient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes 2 No Investigation

2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c License number November 23,2011 D0064502

of death (Item 23a) (Type, Print) 30. Name and address of person who completed c Medical Center Drive, Rockville, Maryland 20850 Brian Carpenter, mo 9901

State Registrar

31. Date filed (Month, Day, Year) 2011

29a, Certifier

32. Registrar's Signature

within 24 hours a

To the Funeral C

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 A^{M} Ray Blankenship December 0230 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ceci1 96 Nottingham Road E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 XM 2 - F Months Hours Min. SEPT TO **Director** Virgi<u>nia</u> 230-42-2985 76 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pine. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 96 Nottingham Road 21921 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black. White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clell Blankenship Lottie Blankenship 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Blankenship/Wife 96 Nottingham Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State December Boulden Chapel Cemetery 10, 2011 Elkton, MD Hicks Home for Funerals, 4 Donation 5 Other (Specify) Signati of Funeral Service Licensee 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ END STAGE RENAL DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the intreatd injector, page 2 should be detached for use as the burial-transit this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregna... ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and file of certifier 29d. Date signed (Month, Day, Year, MD 8 2011 D0062190 Son 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2533 AUGUSTINE HERMAN HWY, SUITE A, CHESAPEAKE CITY, MOZFILS. KHAN SHAHNAWAZ 32. Registra 's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

4 2011

Martin Joseph Campitell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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4	JI		14	U	U	J	U

		1- For State Registrar		Cert	ificate of	Death			Re	eg. No.	. 1003	
Physici edical Exam		1. Decedent's Name (First, Middle Martin Joseph		1					2. Date of Dear Month November	Day Year 18, 2011	3. Time of Death 1331 hrs	
		4a. Facility Name (if not institution 3804 Briars Road	n, give street and numbe	r)		b. City, Town Olney	, or Location	n of Death		4c. County of Dea Montgomery	th	
Funeral Director			6. Sex 7. A	ge (In yrs. las 46	st birthday) Yrs.	If Under 1	Year If Un Days Hou	der 24Hrs ırs Min.		th(MM/DD/YYYY) 9. B Fore 5/1965	irthplace (State or ign Maryland ountry)	
/land -f show any once.	tor		tgomery		Town or Locati Olney			•		0g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 X No	
vith the Maryland 123a or 28a-f show 1 2 notified at once.	Director	10e. Street and Number 3804 Briars Ro	oad			10f. Zip Cod		20832	1	United States		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divo	12. Was Deceder Armed Forces 1 Yes Orced If Yes, Give Year or Dates:		If Ye	s Decedent of es, specify Cu Yes 2 X	ban, Mexica	an, Puerto	pecify Yes or No Rican, etc.)	- 14. Race - Ame White, etc.	white	
036 ithin 72 hours : ne. r than "natury fedical Exami	Completed b	15. Decedent's Education (Spec Elementary/Secondary (0-12) 12	College (1-4 or			t's Usual Öcci ost of working Iyman				Residenti Construct	ial	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Joseph Paul	Campitel1	•			Ar	nita	Louise	Maiden Surname) Wiesner	_	
MD 21 12 should th and Me 27 is ma	To	19a. Informant's Name/Relationsh Anita C. O'Net			3804	Briars	Road		lney, l		20832	
Baltimore, oermit. Pages I am Department of Heal Important: If iten injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Sa	ecify: 🤈	state cr	ace of Disposi ematory or oth tropol:	nerplace) itan Ci	cem.		Date /26/11		ia, Virginia	
		21. Signature of Funeral Service	the		Ρ.	O. Box	5038	, Lay	ytonsvi	Barber Fur Lle, Maryla	and 20882	
Physician /Medical examiner		23a. Part I. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	on each line. a. <mark>Contact Guns</mark> t	not Wound	of Head	e mode of dy	ing, such as	cardiac o	r respiratory arro	est, snock, or heart	Approximate Interval Between Onset and Death	
,	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con									
d sit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):	:							
760, icate be executed physician and the burial - transit	Medical E	UNPENDED	d AMENDED									
Box 68760, e death certificate be the attending physicied for use as the buri	Physician/Me	23d. Date of delivery b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) g Unknown										
P.O. E es that the c igned by the detached	by	Part II. Other significant condition	ons contributing to dea	ith but not res	sulting in the u	nderlying cau	se given in	Part I.		obacco use contribute to	o the cause of death?	
Vital Records, hysician: The law requir this certificate has been siderector, page 2 should t	Completed								1 Yes	sy prior to med? death?	nutopsy findings available completion of cause of	
ital ician: s certi rector	Be	25. Was case referred to medical examiner?	Hospital:	ient 2 E	ER/Outpatient		Other			Residence 6 🗸 Oth	or Scone	
Of ag P	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date of In FOUND: ing	jury ,Year)	28b. Time of Ir FOUND: 1320 hrs	njury 28c.	Injury at Wo	ork?	•	now injury occurred		
Division Hospital or Attendio A hours after death. Funeral Director: A	Certification:	3 ✓ Suicide 6 Could 4 Homicide determ	tigation Nov 18, 201 28e. Place of mined (Specify) Si	Injury - At hor	me, farm, stree	et, factory, offi	ce building,			Street and Number or Fitate) oad, Olriey, MD	tural Route Number, City	
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier (Check only one) 2 Medical Exam	nysician: To the best of in miner:On the basis of ex and manner stated	amination and	e, death occur d/or investigat	red at the time ion, in my opi	e, date and prion, death	place, and occurred a	due to the caus at the time, date	e(s) and manner as sta and place, and due to t	ated. the cause(s)	
H & F 2	Me	29b. Signature and title of certifier		125	>		ense numbe C.M.E.	er		29d. Date signed (M November 19, 2		
6		30. Name and address of person Russell Alexander MD	/			W. Baltimo	ore Stree	t, Baltim	nore, MD 21	223		
S	tate trar	31. Date filed (Month Dey, Year)	-EUII //	rar's Signatur	e k							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ter FH G923 1/04/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Charles Cronenberg Jr. November 25, 2011 3:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Collington Nursing & Rehab. Ctr. Mitchellville Prince George 5775-26×7844 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/19/1915 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours **Director** 1**XX**M 2 - F 214 03 9661 95 North Carolina Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventuals. 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Prince George's Mitchellville 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10450 Lottsford Road 20721 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 X Married þ Yes 2 X No 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Comptroller Dept. of Defense Be Father's Name (First, Middle, Last)
William C. Cronenberg, Sr. 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Catherine Tiencken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith C. Chatterton/Daughter 1005 Timber Creek Drive, Annapolis, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State rematory 11-26-2011 Edgewater, Md. 21037

22. Name and Address of Facility George P. Kalas Funeral Home PA
2973 Solomons Isl. Rd. Edgewater, Maryland Kalas Crematory 4 Donation 5 Other (Specify) 21. Sign the of un all S vice censee 23a. Part 1. Enter the debase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ ementin disease or condition Medical resulting in death) Due to (or as a consequence f) Examiner Failure evialue 5-quentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed COVORAVY attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Diabeles Physician/Medical Mellivus 4 Eaws Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Description of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by degentialie Joint descase 1 Yes 2 No 3 Probably 4 Unknown Completed To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should cardiovanda disasc with Hyperterson 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No ပ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 x Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 🗆 Pending work 1 🗌 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 Xxertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 00042049 ampal Meen 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 20772 Upper Maulboiro Mb. G. CHAMPALOUX mb 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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		Registrar			Certific	cate of	r Death				Reg. No.		
Physiciar Medical Examin		1. Decedent's Name (First, Mic		e						Date of De Month Novemb	Day er 29, 20	Year	3. Time of Death 0030 hrs
		4a. Facility Name (if not institu Southern Maryland (tion, give street a	nd number)			4b. City, Town, o	r Location o	of Death			ounty of I	
Funeral	7	5. Social Security Number	6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Yea			8. Date of E	Birth(MM/DE		9. Birthplace (State or oreign
Director		228-80-0814	1 M 2	()F	58	Yrs	Months Day	/s Hours	y IVIII I.	01/25	/1953		Country) VA
any	ŀ	Usual Residence of Decedent 10a. State 10b. Count	у	10	Oc. City, Tow	n or Locat	ion						10d. Inside City Limits
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	DIFECTOR	10e. Street and Number	1ill Rd.	•	-		10f. Zip Code 207	43			10g. Citizer	of What	-
h with the ems 23a	runerai	11. Marital Status	12. Wa	s Decedent Eved Forces?	/er in U.S.		as Decedent of Hi es, specify Cuba				No- 14	Race - A	American Indian, Black,
ifter deat	by run		Manieu	res 2 X	No		Yes 2 X No			,	Sp		Black
hours a	9 -	15. Decedent's Education (Sp	ecify only highes			. Deceder during m	nt's Usual Occupa ost of working life	tion (Give	kind of wor use retired	k done i)	16b. Kin	d of Busin	ess/Industry
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21215-0036 Muld be filed within 7 Mental Hygiene Hage event, the Medica		17. Father's Name (First, Midd	e, Last)					18.Mother	's Name (F	irst, Middle	, Maiden Su	rname)	
D 21215-(should be filed v and Mental Hygi 7 is marked oth natic event, the		Waverly Smit 19a. Informant's Name/Relation)	1	9b. Mailine	g Address (Stree	Red	a Boo	th al Route Ni	ımber. Citv	or Town. S	State, Zip Code)
MD id 2 shou lith and 1 is 27 is 1		Charlene Chig			8	10 8t	th st. Н	102,	Laure	l n MD	2070	7	
Baltimore, ME permit. Pages I and 2 si Indopertment of Health at Important: Ittem 27 injury or other traums		20a. Method of Disposition 1 X Burial 2 Cremati	on 3 Remo	val from State	crema	atory or oth	sition (Name of ce her place)		/	Date			ty or Town, State
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		South -	tuni	Chi	ار	E	500 All	entow	n Rd.	- Cam	ip Spr	ings	¬ MD 20748
Physician \/Medical		23 Part I. Enter the disease failure. List only one cause	e on each line.				, ,						Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)	Due to (or	as a consequ		erosc	elerotic	Card	iovas	CULAI	Dise	ase	
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8760, tificate be execung physician and as the burial - tra		F FEMALE:		yes, outcome	of pregnancy	y					23d. D	ate of de	livery
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D. Box 6(): the death cert by the attendir tched for use a		1 Yes 2 No 9 ✔ U	nknown -	Jnknown	ic or death	5 Ot	her (Specify)						
that the ned by a detache		Part II. Other significant cond		-		-		given in Pa	rt I.				te to the cause of death? Probaoiy 4 Unknown
ds, equires		<u>Schizophreni</u>	a;Diabet	es mer	IILUS;	obes	ııy			24a. Wa:	s an		re autopsy findings available
of Vital Records, P.O. og Physician: The law requires that the After this certificate has been signed by meral director, page 2 should be detach and To Re Completed by D.										perf	opsy ormed? 2 No	deat	r to completion of cause of th? Yes 2 No
Vital Recysician: The his certificate director, page		25. Was case referred to medic						of Death	(Check onl		2		100 2 10
Physici r this o	2 L	examiner? 1 ✓ Yes 2 No	Hospital: 1		2 🗸 ER/0			Other ₄		lome 5	Residence	9 6 □ 0	Other:
Division of Vital Records, P.O. Box 6 the Hospital or Attending Physician: The law requires that the death cent fin 24 hours af or death. The Funeral Director. After this certificate has been signed by the attending repletely filled: The Robert of Completely of the Completely of Physicial Completely in the Physicial Completely of the			nding	Date of Injury Month, Day,Year) 28b.	. Time of la		ryat Work Yes 2	- 1	d. Describe	how injury	occurred	
Division o spital or Attending sours af or death, norral Director. After filled it by the fune	3	3 Suicide 6 Co	uld not be		y - At home,	farm, stree	et, factory, office b	ouilding, etc	c. 28	or Town,		Number o	or Rural Route Number, City
Hospita Puncral Funcral		4 Homicide	Physician: To the		nowledge, de	eath occur	red at the time, da	ate and pla	ice, and du	e to the cau	use(s) and n	nanner as	stated.
To the Ho within 24 To the Fu completely	<u> </u>	one) 2 Medical Ex		asis of examin	ation and/or	investigat			curred at th	ne time, date			
		29b. Signature and title of certi	hami	11/1	A		29c. Licens O.C.					e signed n ber 29	(Month, Day, Year) , 2011
2 5	+	30. Name and address of person Melissa Brassell, MD					. Baltimore S	treet P	altimoro	MD 242	223		
Stat	e			2. Registra s			. Daitimore 3	incel, Di	aitii IIOFE	, IVIU 212	.20		
Registra	ī	11. DEC 1 2 2011	Lenen	U \$.	gar		_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last)
Corina 3. Time of Death Connors Nov . 26 Pay 2011 Year Physician/ 1014 Medical 4b. City, Town, or Location of Death
Takoma Park 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** Montgomery Washington Adventist If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 🗆 M 2 🔀 Days Hours 8 1 0 1 1 0 1 1 1 9 2 8 Japan 213-84-2697 83 Director Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director MD Examiner must be notified Prince George Adelphi 1 🗆 Yes 2 🎽 No 28a-f 23a or 2 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Britain 20873 1801 Mezzerot Road Rm.214 items ; death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 5 1 Never Married 2 Married þ hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Asian id Mental Hygiene. marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ta York Do Do Set San 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corina Jones/Daughter 10958 25 Dennis Drive New Hampton, N.Y. 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Date emetery, crematory or other place) 1 🗌 Burial 2 🔯 Cremation 3 🗌 Removal Chesapeake Crem. 11/29/2011 Beltsville, Md 4 Donation 5 Dother (Specify) uneral Service License PHITE TO COLORS OF THE ALDI FUNERAL SERVICE, P.A 21. Signative 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final noumona Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 12050 Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Tansit requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician or use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death the hed 9 Unknown 9 Unknown cate has been signed by i page 2 should be detach Part II. Other significant conditions contributing to/death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 🗌 Yes Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has be completed filled in by the funeral director. performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No 1 🗌 Yes Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 186

Registrar

State

31. Date filed (Month, Day Year)

NOV 30

KOCKNIKE MIS 20852

of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

3. Time of Death November 28, 2011 4:05 P M Montgomery Birthplace (State or Foreign Country) New York 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? United States 14. Race - American Indian Black, White, etc. white 16b. Kind of Business/Industry U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14814 Eastway Drive, Silver Spring, MD 20c. Location - City or Town, State Falls Church, VA MOLCOS 254 Carroll St., NW, Washington, DC 20012 Interval Between Onset and Death 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) November 28, 2011 Sirah Lemma, M.D., 1500 Forest Glen Road, Silver Spring, MD 31. Date filed (Month, Day, Year) NOV 3 0 2011

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per med cert G922 12/28/11 dk
State of Maryland / Department of Fleatth and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19,2011 SHARON R. CRAFT November 7:30pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1001 Spring Valley Court Fort Washington Prince George's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) t. 7,1967 Virginia 44 **Director** 226-06-8039 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 XYes 2 ☐ No MD Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 1001 Spring Valley Court 20744 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ö by X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 XNo Specify: "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant NW Systems event, Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othn any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Clarence Ray Craft Barbara Gail Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara G. Craft / Mother P.O. Box 424, Hurt, VA 24563 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State New Bethel Missionary

Church Cem. 11/26/2011 4 ☐ Donation 5 ☐ Other (Specify) Hurt, VA 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service-License ba 7400 Georgia Ave., N.W. Washington, DC 20012 23a. Ray 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for de a contraction ou cry e attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Day Month Year Pregnant at time of death 5 Other (specify) page 2 should be detached signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 5 \square Pending 1 X Natural 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Jocelyne Koualchou, mi 163 748 November 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 4041 Powder Mill Road, #600, Calverton, MD 20705 31. Date filed (Month D.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}7,2011 November Edith E. Chatman 6:00 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center <u>Prince George's</u> Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 578-40-9549 81 Director 1 □ M 2 🛛 F 05/21/1930 Wash.,D.C. Usual Residence of Deceder 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Yes 2 No Md. P.G. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 611 Birchleaf Avenue 20743 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2X Married Yes 2X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2√2 No Specify. "natural", Specify: Completed 3 Divorced 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) 12th Lunch Server/Book Clerk D.C. Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0 Parker Marshall, Sr. Martha Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Clifton J. Chatman, Jr. / Husband 611 Birchleaf Ave., Capitol Heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, Maryland Veterans Cem. 12/07/11 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. STAU 4925 Burroughs Ave., N.E., Washington, D.C. 23a. Part X. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ovasian Cancer with Metastasis Ph_sician/ Malignant disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi). Exami Cause (Disease or Injury that initiated events burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown the 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pleveal 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: ဂ္ npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nu/se Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 6 gi 29d. Date signed (Month, Day, Year) MM D69796 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) Jagder Sins 3001 HOSPITAL DRIVE CHEVELLY MD MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22,201 5:15P M Physician/ NOV. ELENA LAY CHANG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death MONTGOMERY THE VILLAGE OF ROCKVILLE ROCKVILLE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Security Number Age (In yrs. last birthday) **Funeral** Hours. Months Days AUG13, CHINA 216-04-2871 1 □ M 2 🔀 Director Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a State 10b. County 10c. City. Town or Location Director ROCKVILLE MONTGOMERY MD. 1X Yes 2 No 10e. Street and Number 9701 VEIRS DRIVE 10f. Zip Code 10g. Citizen of What Country? USA 20850 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married Completed by CHINESE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 XWidowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER AT HOME YRS Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN UNKNOWN ဥ 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) SWEETWOOD COURT, ROCKVILLE, MD • 20850 PATTY CHANG 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition GATE OF HEAVEN CEM-11/26/11 SILVER SPRING, MD. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2222-WISCONSIN AVE., NW Signature of Funeral Service Licens-22. Name and Address of Facility HYSONG CO.INC. WASHINGTON, DC 20007 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause on and h line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical or as a consequence of Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last as a consequence of ending physician are use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No for Month Day Year signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) BB examiner? 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No iniury 1 Natural 5 Pending ☐ Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License numbe

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause

2011

31. Date filed (Month, Day, Year)

9701 VEIRS DRIVE,

20850 -DR. CHARLES KARESH

of death (Item 23a) (Type, Print) ROCKVILLE, MD. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Marylar		artment of F			iene eg. No.				
	Physiciai Medic	n/	1. Decedent's Name (First, Middle, Last) Marie Ann	Cole				2. Date of Death Month Decemb	er Day 10 2 Jean	3. Time of Death 6:03 P M			
	Examine		4a. Facility Name (if not institution, give str Frederick Memor				Location of Death rederick	4c. County of Death Free	derick				
	Funeral Director		100 10 001/	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.						
	aryland a-f show fied at	- 1	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic		ty, Town or Lo Freder					10d. Inside City Limits 1 → Yes 2 □ No			
	with the M 23a or 28 ist be noti	eral Dir	10e. Street and Number 101 Linden Avenu	e		10f. Zip Code 2170)3	1	10g. Citizen of What Country? U.S.A.				
036	e filed within 72 hours after death with the Maryland theygiene. All thygiene and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 🌂 No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 Yes 2 Xo		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W				
Maryland 21215-0036	nin 72 hou ne. han "nat u e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give life. D	dent's Usual Occup kind of work done o DO NOT use retired) Homemake	during most of work	ing	16b. Kind of Business Own Hom				
and 21	be filed with lental Hygier rked other i tic event, th	0)	17. Father's Name (First, Middle, Last) Karl Artinger			Tromemake	18. Mother's Nam Eliz	ne (First, Middle, M Sabeth Sc					
Maryla	12 should be file bith and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Type William R. Cole, S		19b. Maili 101	ing Address (Street & Linden	and Number or Rur Avenue, F	al Route Number rederick	City or Town State Zin	Code)			
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er once.		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20h.	Place of Disponentery, cre	osition (Name of matory or other plac LIVET CEM	etery Dec	Date 20	20c. Location - City or 011 Freder	Town, State			
Balti	permit. I Departm Importa any inju		21. Signarura of Funera Service Lice e	MO025	55 2	^{2. Nam} gand Addre 106 East	స్థో affict ^{ly} Bas Church St	sford PA ., Frede	Funeral Ho erick, MD 2	me 1701			
	nysician/ Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the deacause on each line. Due to (or as a consec	DNCCA		ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Proper and Death			
00	be executed sician and burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last										
Box 6876	e death certificate b the attending physi hed for use as the b	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	ic. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	☐ Ectopic pregnan ☐ Other (specify) _	су		23d. Date of de Month	livery Day Year			
ls, P.O.	requires that the de been signed by the should be detached	ed by Ph	Part II. Other significant conditions con	tributing to death but not re	esulting in the	underlying cause gi	iven in Part I.		obacco use contribute to Yes 2 □ No 3 □ F	o the cause of death? Probably 4 Unknown			
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Vital	lysician: is certifi director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	☐ ER/Outpatio	Oth	Place of Death (Chec ner: 4 Nursing F		lence 6 Other (Spec	cify)			
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Divisi	ital or Att. Ins after de al Directo led in by t		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci	ify)			City or Tow					
	the Hospi nin 24 hou the Funer npleted fil	Medical	(Check Medical Examine only one Certifying Nurse	cian: To the best of my kno er: On the basis of examinati Practioner: To the best of	on and/or inve	estigation, in my opin , death occurred at t	ion, death occurred he time, date and pla	at the time, date and due to the	nd place, and due to the e cause(s) and manner as	cause(s) and manner stated stated.			
9	To with		29b. Signature and title of certifier 30. Name and ddress of person who come to the company of the company of the certifier.			29c. Licens			29d. Date signed (Mont				
	12 /		30. Name an oddre of person who con	mpleted cause of death (Ite	em 23a) (Type,	Print	PERRO	uceno	2/702				

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) **DEC 1 5 2011**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Amend Item 2	State of Marylan 25 per me, g922	d/Depa ,12/26	artment of Hea /2011dhb <i>tificate of De</i>	alth and Mental	Hygien Reg. N	1e 2011	40107			
ľ	Physicia		1. Decedent's Name (First, Middle, Las	· · · · · · · · · · · · · · · · · · ·			2. Date of	f Death	23, 2011	3. Time of Death 11:15p M			
-00	/Medic Examin	-	4a. Facility Name (If not institution, give			4b. City, Town, or Lo	ocation of Death	4	c. County of Death				
أتمم			Future Care - Ir			Baltir			N/A				
l.	Funeral Director		144-28-8798	ex	last birthday) Yrs.		Hours Min. 8. Date of Mont. Feb.	16, Day, Yea	r) Cour	place (State or Foreign htry) nnsylvania			
	and ow	,	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation			1	0d. Inside City Limits			
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	th the)irec	10e. Street and Number			10f. Zip Code		10g. 0	Citizen of What Cour				
	23a ust b	<u>ra</u>	1195 Hillcrest Ro	oad			113		U.S.A				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Everyland in actified a once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Worced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuban,	anic Origin? (Specify Yes o Mexican, Puerto Rican, etc Specify:	or No- .)	lo- 14. Race - American Indian, Black, White, etc. Specify: White				
9	2 hour	ted	15. Decedent's Ed	ucation		dent's Usual Occupation		16b.	Kind of Business/In	dustry			
215	thin 72 e. an "na Medi	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give life.	kind of work done duri DO NOT use retired)	ing most of working						
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Maryland 21215-0036	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last)	Undnamı		18	B. Mother's Name (First, M Mary Elizab						
ž	hould nd Me marke	၉	Paul Alexander 1 19a. Informant's Name/Relationship (19b Maili	ng Address (Street and	Number or Rural Route N			Code)			
	nd 2 salth ar		Michele Doughert	-		•	Road, Odent						
altimore,	es 1 a of Hei		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other place)	Date	20c.	Location - City or To	own, State			
Ē	Page ment ant: If ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State		ematory	12-2-2011		ltimore,	MD			
Balt	permit. Depart import any inj once.		2 Signature of Funeral Service Licen	MODER	11	2. Name and Address of 6512 NW Cr	of Facility Beall ain Hwy, Bow		al Home D 20715				
			23a. Part 1. Enter the disease, or companies shock, or heart failure. List only	olications that caused the death	h. Do not en	ter the mode of dying,	such as cardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death			
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-	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	FAILURG							
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68760,	ficate be executed physician and s the burial-transit	dical		d. SKIN	Woun	DS	O M	ONED BY ME	DICAL EXAMINER				
	ding p		IF FEMALE:	23c. If yes, outcome of pregna	ancy		CERTIFICATION			-			
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	res that signed b	by	Part II. Other significant conditions of	ontributing to death but not res		nderlying cause given	in Part I. 23e.		co use contribute to	the cause of death?			
oro	w require been si should t	eted			<u> </u>			•					
Vital Records,	The law ate has t page 2 s	Completed	HBP	llitus			24a.	Was an autopsy performed res 2	prior to co	opsy findings available ompletion of cause of			
/ita	ding Physician : The I h. After this certificate ha funeral director, page	Be (25. Was case referred to medical examiner?	Hamilali			6. Place of Death (Check	only one)					
	Physical this call direction	<u>د</u>	1 Yes 2 No.	Hospital: 1 Inpatient 2 I	ER/Outpatie		4 Denursing Home 5		6 ☐ Other (Spec	ify)			
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Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to	Certification: To	3 Suicide 6 Could not be determined		ome, farm, st fy)	reet, factory, office		tion (Street or Town, St	t and Number or Ruitate)	ral Route Number,			
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C		nysician: To the best of my kno niner: On the basis of examina and manner stated.									
	To the within To the Comp	Me	29b. Signature and title of certifier	1		29c. License n		29d.	Date signed (Month	, Day, Year)			
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	41		Name and address of person who RICHARD Car	ey ino 2	2 S. A		BAUTIMON	, he	9. 21	229			
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 9 2	32. Registrar's Signa	ature	Santes!							
				- Later - Late	A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death November Day 16 2011 Physician/ 2010 Lloyd Dickerson Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, g. Birthplace (State or Foreign **Funeral** . Virginia Months Day, Y. 236-42-7463 W. 1930 Director 1 🗶 M 2 🗆 F Nov 80 Yrs. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Anne Arundel Lothian 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 909 Bayard Rd. 20711 items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö à 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Anne Arundel Co. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education Chief Custodial Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Myrtle V. Bradley Emmett W. Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lothian, Md. 20711 Nellie Dickerson(Wife) 909 Bayard Rd. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11-22-11 U.M. Church Lothian, Md. Adams 4 Donation 5 Other (Specify) Whene a Received Facility Sons Mortuary, 21. Signature of Funeral Service Licensee 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ye each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ration disease or condition resulting in death) Medical Due to (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ondenying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a 2 No a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner?

1 Yes 2 40 Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 Pending after death. Director; Aff 1 🗌 Yes 2 🗌 No 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only of Signatu 29d. Date signed (Month, Day, Year) D16376 no completed cause of death (Item 23a) (Type, Pr 2001

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 28 2011 1:35 Ам Marlene Ann deBethizy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lothian Anne Arundel 202 Fifth St. 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 219-42-2712 1 □ M 2 □**X**F 66 4/28/1945 MDUsual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Anne Arundel 1 🗌 Yes 2 🗶 No MD Lothian 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral USA 202 Fifth St. 20711 items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: White Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Property Management Accountant Be traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward deBethizy Theresa Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 202 Fifth St., Lothian, MD 20711 Scott Madden - Son other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important; If its any injury or of once. P 1 Burial 2 Temation 3 Removal from State Kalas Crematory 11/28/2011 Edgewater, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Non SMALL Immediate Cause (Final .Physician/ SHTYOME disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Directo (of sets consequence of) cause. Enter Underlying Examir burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for signed by the at Id be detached for Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perforn death? certificate 1 Yes 2 No ☐ Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 🗌 Yes 2 🗌 No 5 Pending hours after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check

DHMH 17 Rev 06-2011

State

Registrar

29b. Signature

NOV 2 9 2011

death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

11/28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar 40110 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11/27/2011 10:00A Barbara Frances Di Chiro Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5719 Kingswood Court Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Min 1 M 2X F Hours. 02/05/1928 Massachusetts Director 017 22 2326 83 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5719 Kingswood Court 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 🔼 No 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Elementary School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles A. Phillips Dora Pezzetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Giovanna Di Chiro / Daughter College St. #29 South Hadley, MA 01075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State National Crematory 11/30/2011 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA . Signature of Funcial Service Licensee 22, Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Lung Disease Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Linter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and the for use as the burial that or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for a in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Lung Mass, Adrenal Mass Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/29/2011 D23170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gita C. Bakshi MD 9404 Old Georgetown Rd. Bethesda, MD 20814 31. Date filed (Month, Day, Year 37. Registrar's Signature State NOV 3 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 5. per fh, 9922 12-16-11 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov. 26.2011 1615 Yadi Dadras Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last hirthday) **Funeral** 8 Date of Birth Months Days Hours Mir 1M973.03 Y 19944 1 🎽 M 2 🗆 F **Director** 67 226-13-0876 Usual Residence of Dec 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director or 28a-f sh notified a MD Montgomery Bethesda 1 ☐ Yes 2 🔀 No 10e. Street and Numbe ö 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 8401 Old Seven Locks Road 20817 USA items ? permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ŏ by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1 Yes 2 X No Specify: "natural", Completed 3 Divorced er than "natur , the Medical B 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant f Health and Mental Hygien item 27 is marked other the other traumatic event, the Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Abdoulah Dadras Ebtehaj Ovissi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laila Dadras/Wife 8401 Old Seven Locks Road Bethesda, Md20817 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 11/30/2011 Rockville, Md 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem.Park PHOLEPODERINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 21. Signatu Muses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Asthma Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami The law requires that the death certificate be executed Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Day Year Pregnant at time of death Unknown signed by the at d be detached for 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should peen 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 autopsy perform death? 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 XNo Other: 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death al or Attending Ph s after death. Il Director: After th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No completely filled in by the 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cortifying Nurse Prontitionar T. the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaviani M.D.

31. Date filed (Month, Day, Year,

NOV 3 0

D0055938

10215 Fernwood Road #315 Bethesda, Md 20817

Nov.29,2011

11-08889

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mended	item 1- For State
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F	uneral		5. Social Security !		6. Sex		7. Age (In yrs. lasi	t birthday)		If Under		If Under	24Hrs.	8. Date of E	Sirth (MM	/DD/YYYY)	9. Birth	nplace (State or
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215 e file	ked t	Be	Joseph W	lade									Ther	esa	Burne	tt			
24 Pala	and Mental Hygiene. 7 is marked other th	2	19a. Informant's Na		hip (Type	e, Print)			19b. Mailir	ng A	ddress (Street a	and Numl	ber or Ru	ral Route N	ımber, C	ity or Town	, State,	Zip Code)
MD d 2 sho	27 is		Martin W	lade (brot	her)			288 V	Ves	st Fo	rk	Dr.	Leag	ue Ci	:у,	TX 77.	573	
e, I	n of Health and Mental Hygiene. it: If item 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis						ace of Dispo			of ceme	etery,		Date	20c.	Location -	City or T	own, State
Baltimore, MD 21215-0036 Jegus 1 and 2 should be filed within 72 hours after death with the Maryland	oth of		_	X Cremation		Removal fr	om State		State			tor	,,	11/2	8/201	ı mi	11sbo	ro	DE
it. F	ortan	М	4 Donation 5	Qther S		•		1150							_	_			
Ba	Department of Health a Important: If item 27 injury or other traum:		21. Part of Fun Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811													iome			
	sician			3a. Tart I. Enter this disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and															
/M	edical		failure. List only one cause on each line. Between Onset and Death Death																
£xa	miner		Immediate Cause (Final disease or condition resulting in death) a. Head and Neck Injuries Due to (or as a consequence of):																
			Sequentially list conditions, b.																
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Division of Vital Records, tal or Attending Physician: The law require	this certificate has been signed by the attending il director, page 2 should be detached for use as	Be	25. Was case refer examiner?	red to medica	_	pital:	_			_			<u> </u>	Check on		7		7	
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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2 should be filed within 72 hours after dea th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner.	- 1	19a. Informant's Na			rint)			19b. Mailir	g Address	s (Street a			al Route Numb	per, City o	r Town, Sta	te, Zip	Code)	_
and 2 s lealth am 27 her tra		Stephen 1		erg -	Son						n St		Fulto	_				_
ige 1 ant of H		20a. Method of Disp 1 🖾 Burial 2	☐ Cremation		oval from St	ate	cer	netery, cren	sition (Nar natory or c emori	ther place	e)		Date		_ocation - C	,	own, State	
permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once.		4 ☐ Donation 21, Signature of Fur				_	Gara				s of Faci		5/2011 rd Sag		lney, unera		irection,Ir	no
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ath certifics attending p I for use as t	cian/	23b. Was decedent in the past 12 r	months?		f yes, outco I ☐ Live Bir I ☐ Pregna	th 2	Petal o	death 3	Ectopic Other (s		y				23d. Date Mont		very Day Year	
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ian: Th rtificat stor, pa	Be C	25. Was case referre examiner?	ed to medical							26. Pla	ice of De	ath (Chec	l 1 ∐ Yes k only one)	2 11	No. 1 L	Yes	2 🗆 No	
hysici this ce al direc	၉	1 🗆 Yes 2 🖸	No	Hosp	1 M In			R/Outpatier			4 L I	Nursing Ho	ome 5 🗆 Res	sidence	6 🗌 Other	(Specit	(y)	
ding F th. After t funera	cate:	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	1 5 ☐ Pendii Investi	ng	8a. Date of (Month,			8b. Time of injury	M 2	8c. Injury work?			28d. Describe	how inju	ry occurred			
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2	Certifying Medical I	Examiner: (In the basis	of exa	amination a	and/or invest	igation, in	my opinio	n, death (occurred a	t the time, date	e and plac	e, and due to	o the ca	ause(s) and manner state	ed.
Somp # thin	≥	29b. Signature and	A				oot or my n	inoviougo, c		. License	number		e, and due to		ate signed (i			_
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		30. Name and addre		Who comple	eted cause	of dea	ath (Item 2	3a) (Type, P	rint)	1018	Pr	inc	e Ph	ilip	Dr. (VIC	rey, Md.	
State Registra	7	31. Date filed (Month	h, Day, Year)	2011	32 Reg	istrar	's Signatu	ba	KA)					•			·	
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State Registrar

DHMH 17 Rev 1/2001

OCMF 2006

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

December 1, 2011

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/27/2011 Year Physician/ 3:50 AM Margaret Lambertson Ennis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Pocomoke City Worcester Hartley Hall If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)

MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2X F Hours 10-23-1924 219-14-4666 87 Yrs. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21851 USA 4016 Whitesburg Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Š 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3X Widowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ permit. Page 1 and 2 should be 1 Department of Health and Ments Important: If item 27 is marked Rena Powell Carl Henry Lambertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4153 Whitesburg Rd. Pocomoke City, MD, 21851 Linda Ennis/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Rehobeth Baptist Cem. 12-3-2011 Rehobeth, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home P.A. 107 Vine St., Pocomoke City, MD, 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ CEREBROVASULAR ACCIDENT disease or condition resulting in death) Medical Examiner DISEASE STAGE KIDNEY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami physician and the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. N page Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

I Director: After this id in by the funeral di 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Wil 29d. Date signed (Month, Day, Year) 0 62172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sharan (Market 1604 MARKET ST. POCOMOKE CITY MD BA 6 JATYAL, MO 32 Registrar's Signature 31. Date filed (Mont State 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 19 2011 Physician/ 10:01P M November John R. Fountain Sr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Hospice House Harwood Anne Arundel If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Davs Hours 1934 Maryland 220-30-2286 Sept **Director** 1**X** M 2 □ F 77 Usual Residence of Decedent show or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No Maryland Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ritems 23a or ner must be n Funeral 20764 USA 1466 Cedarhurst Rd. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Black "natural". Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Anne Arundel Co. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Board of Education 6yrs Principal Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental H 2 John Fountain Mildred Gross ye 1 and 2 should b t of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is 7 or other tra Shady Side, Md. 20764 Teresa Fountain(Wife) 1466 Cedarhurst Rd. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b**T**Plack об Гівроуі і фл (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Memorial Gardens 11-25-11 Davidsonville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Amame Recose of ScilisSons Mortuary, P.A. 21. Signature of Funeral Service Licensee Ham 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Parkinson's Immediate Cause (Final 1) isease years Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): executed and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the at signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has pade 2 death?
1 Yes 2 No certificate 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d Describe how injury occurred iniury 5 Pending **Natural** within 24 hours after death. To the Funeral Director: A Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11/21/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Parkway Annapolis, Md. 2140/ selonick, MO 2003

State Registrar

31. Date filed (Month, NOV 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}6. Physician/ Fraundorfer 2011 Joseph L. 12:46P. M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Takoma Park** 4c. County of Death
Montgomery Examiner Washington Adventist Hospital 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday **Funeral** Days Hours Nov. 6,1922 Pennsylvania 193-14-5241 89 Director 1 X M 2 □ F f show 10d. Inside City Limits 10b. County 10c. City, Town or Location : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director Maryland | Prince George's 1 Yes 2 □ No Berwyn Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 5803 Pontiac Street 20740 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 10/12-10/ 11. Marital Status 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify 3 X Widowed 4 □ Divorced IT Yes, Give Year or Dates 1943–1946 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) US Government Postman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Francis X. Fraundorfer Anna Yeager and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886Joseph A. Fraundorfer -son 18809 Walkers Choice Road Montgomery Village, MD f Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or oth 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 12/2/2011 SilverSpring, Maryland 4 Donation 5 Other (Specify) ervice llicensee Signature of Bonald Wire Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine cause. Enter Underlying attending physician and for use as the burial transi Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death been signed by the a a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performer within 24 hours after death.

To the Funeral Director: After this certificate has page 2 death? filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 \sum Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 5 Pending injury Natural Accident 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

the

9

State

only one

29b. Signature and title of certifier

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and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

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mended it Physic Me			Name (First, Middle	er f.h. 11 e, Last) Dyce		cost	tinca	- 01 2		E.T,	2. Date of De Month Novemb	eath	Non G	Year 2011		of Death
APPEAR	niner			, give street and nur	· ·				Location			4	c. County	of Death		
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21215-0036 within 72 hours after gjene. er than "natural", o , the Medical Exami	Completed			nt's Education est grade completed College (*) -4 or 5+)	life. D	kind of w O NOT u	ual Occup ork done o se retired)	ation <i>luring m</i> os	t of work	ing		Kind of Bu		ndustry	
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Baltimore, permit. Page 1 and Department of Hes Important: If item any injury or othe				3 ☐ Removal from Specify)	Ctoto (Place of Dispo cemetery, crer isbury	natorv or	other plac	е) • У		Date 3/2011	1		-	own, State	
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Division of Vital Records, all or Attending Physician: The law requires s after cleath. In Director: After this certificate has been signed in by the funeral director, page 2 should be	Complet										24a. Was auto perf 1 \(\sum \) Yes	opsy formed2		death?	opsy finding ompletion o	gs available of cause of
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ivision or Attendii after death. Director: At	Certificate	2 Accide 3 Suicide 4 Homici	nt Investig	gation not be 28e. Place	of Injury - At ho	ome, farm, str	M eet, facto	1 🗆	Yes 2		28f. Location City or To			er or Rura	al Route Nu	ımber,
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To the Comp	2		and title of certifier				29	lc. License	number	·		29d. D	ate signed	d (Month,	Day, Year)	
3)	47	30. Name and a	ddress of person v	who completed cause	se of death (Item	n 23a) (Type, F	Print)	5.010	1510~	1 51	en s	s4us	BURY	, ^	10 21	1504
	tate trar	31. Date filed (M	NOV 2	32. F	Registrar's Signa		,							.		

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Medic Examin	er	4a. Facility Name (if	fnot institution, d Assis	give street and n	umber)	- 10 E		Town, or 1		of Death		4c.	County	of Death	
Funeral Director		5. Social Security N 508-28-2 Usual Residence	141	6. Sex 1 ፟፟፟፝ M 2 ☐ F	7. Age (In yrs. 89	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug • 24	v. Year)	922	Count	lace (State or Foreign ry) 'aska
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permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marr 3 ☒Widowed		Armed	s 2 🔀 No Bive			ify Cuban	, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)		Black	- America k, White, e Whit	tc.
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 🔲 Liv	outcome of pregn ve Birth 2 Fet egnant at time of oknown	al death 3	☐ Ectopic p☐ Other (sp		,				23d. Date Mor	e of delive	ry Day Year
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Physician: T this certifica eral director, p	: To Be	25. Was case refermexaminer? 1 Yes 2 27. Manner of Deat	No		☐ Inpatient 2 ☐	ER/Outpatie		Other	4 N		k only one)				
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To the Ho within 24 To the Fu completel	Med		☐ Certifying		pasis of examination er: To the best of		, death occi	urred at the License	e time, da number	ate and pla	ace, and due to	the cause((s) and m		
12 m		30. Name and addr	ress of person w	ho completed ca	use of death (Iter	n 23a) (Type, I	Print)	D2 POF				-	2/	6/1	21769
Stat		Jam 31. Date filed (Mont	th, Day, Year)	/ 32.	Registrar's Signa	ature &	D				MODE	3070.	ייין גע	MO	2(167
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MoNov. 26ay, 201 14a Audrey 7:40p Guthrie Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery Chevy Chase Manor Care Chevy Chase 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 246-36-6538 **Funeral** Hours 96 N.C. 3 7 2 8 7 1 9 1 5 1 □ M 2 🔀 **Director** or 28a-f show notified at within 72 hours after death with the Maryland Oa. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Chevy Chase 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ıral", or items 23a oı Examiner must be Funeral 8700 Jones Mill Road 20815 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene.
7 is marked other than "I traumatic event, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Wesley Guthrie Esther Headen traumatic Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce, Janice Guthrie/Daughter 8715 1st Avenue #1211D Silver Spring, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State Chesapeake Crem. 11/29/2011 Beltsville, Md 4 Donation 5 Other (Specify) P#None Ades RENALDI FUNERAL SERVICE, P.A. 21. Signatul 9241 Columbia Blvd.Silver Spring,Md20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Cus to for ea a consequence of If any, leading to immedicause. Enter Underlying for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed After this certificate 2 1 No 1 Yes rs after deau... ral Director: After this cerum. ral in by the funeral director, pr 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier DOOT 7114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive #206 Rockville, Md 20850 Truong Bao MD

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

NOV 3 0 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month BARBARA ANNE GRIFFITH 2011 4:50 A^M NOV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY BETHESDA WRNMMC 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Y Months Days 1 🗆 M 2 😾 F Hours Min. Year 1950 257-78-2767 Tennessee **Director** 61 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Virginia| Fairfax Lorton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6765 Blanche Drive 22079 USA permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important! If item 27 is marked any injury or at 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fred Malner Martha Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. Griffith / Husband 6765 Blanche Drive, Lorton, VA 22079 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 T Cremation 3 Removal from State Donation 5 Other (Specify) National Crematory Dec Ol, 2011 | Falls Church, Virginia 21. Signature of Funeral Service Conge 22. Name and Address of Facility Demaine Funeral Home 5308 Backlick RD, Springfield, VA 22151 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CIRRHOSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown jo Pregnant at time of death Month Day Year 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 X No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ٩ 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 7/2009

State

only one

29b. Signature and title of certifie

30. Name and address of person

JIAN MING MEI, 31. Date filed (Month, Day, Year)

NOV 3 0 201

68760

P.O.

Division of Vital Records,

backer

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

VA 0101242154

29d. Date signed (Month, Day, Year)

28

NOV

WRNMMC, BETHESDA, MD 20889 5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 Day 2 Year 17:56 M Medical 4a. Facility Name (if not Institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Min. (Month, Day, Year) **Director** 419-22-9887 1 🕅 M 2 🗆 F 07/31/1922 AL 89 show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notifled at 10b. County 10c. City, Town or Location Director MD Columbia Yes 2 No Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7110 Minstrel Way, #25 21045 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \(\text{No.} \) No. 1943-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and Mental Hygiene. Is marked other than "natural", or Completed by 1 Never Married 2X Married 1 X Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 🗆 Widowed 4 🗆 Divorced 1945 Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Architect Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Maggie Oneatha Davis Theodore Rosevelt Gaillard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7110 Minstrel Way, #25, Columbia, MD 21045 Geraldine C. Gaillard/wife 1 and 2 s of Health item 27 i Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of h Important: If ite any injury or oth Page 1 1 Burial 2 Cremation 3 Removal from State Maryland Nat'l Mem 4 ☐ Donation 5 ☐ Other (Specify) 12/01/2011 Laurel, MD permit. 21. Signature of Funeral Service Liger 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SHOCK Immediate Cause (Final SEPTIC Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NEUNONI Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events EBIL the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsv perform death? After this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director:

pompletely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie HASCh MA 62H, 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

State Registrar

Month, Day, Year)
NOV 2 9 2011

Box

Records.

of Vital

Division

Anuradha Arun, M.D., 10301 Georgia Avenue, Suite 209, Silver Spring, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene LN125 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Gill Physician/ Lucille Robinson 2011 Leona 4:00 11 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 12114 Centerhill Street Silver Spring 9. Birthplace (State or Foreign Country) NC If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth . Social Security Number **Funeral** 05 17 1942 Days Months Hours 1 M 2 X 579-56-4702 69 **Director** Usual Residence of Decedent show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20902 USA 12114 Centerhill Street 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) GIST Project Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robinson Eunice Crawford Allen Bundy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21230 1234 Washington Blvd. E. Ursula Young/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland National Ce: 11/28/2011 Laurel, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licent 4217 9th St. NW Washington, DC 20011 uson 23a. Fax 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 15+ years Chronic Obstructive Pulmonary Disease Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) E E and that initiated events Due to (or as a consequence of) resulting in death) Last nding physician a Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atter Year Month Day in the past 12 months?

1 Yes 2 No for 4 Pregnant 9 Unknown Pregnant at time of death been signed by the a should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Mar Probably 4 Unknown Hypertension Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe has page 2 1 ☐ Yes 2 🛣 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical director, æ examiner' Hospital Other: 4 Nursing Home 5X Residence 6 Other (Specify) ျှ 1 Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA this filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After 5 Pending injury 1X Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated npleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8241 Georgia Ave #102 Silver Spring, MD 20910 M.D. Shelley Williams, 31. Date filed (Month, Day, State

Registrar

NOV 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Michael Walter Gero 5:00a M November 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard 6498 River Clyde Drive Highland Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Days 219-46-8002 **Director** 1 **№** M 2 🗆 F 63 California June 09. 1948 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Highland Maryland Howard 1 Yes 2 X No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 6498 River Clyde Drive 20777 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 1 X Yes 2 No
If Yes, Give
Year or Dates. Vietnam Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Computers and Mental Hygier 7 is marked other t Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earle C. Gero Lois A. Heth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Dorothea Clemmer Gero - Spouse 6498 River Clyde Drive, Highland, Maryland 20777 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Pk.: 11/28/2011 | Rockville, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Year Pregnant at time of death ed by the a detached f Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3. Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 No Yes 1 Tes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury s after death. the Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours af ... To the Funeral Di completely filled in Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [To the ! Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of certifier DZ8 135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WISLONSI

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#10b/eperINF, 12/5/11, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 25, 2011 Physician/ 3:45 рм Margaret Ruth Gerhardt November Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Prince George's Renaissance Gardens - Riderwood Silver Spring If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Country Maryland Days Hours (Month, Day, une 30 1 □ M 2 **K** F 93 Director 577-10-2010 une Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Prince George's 1 Yes 2 No Silver Spring Maryland Montgomety 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #1426 Funeral 20904 U.S.A 3160 Gracefield Road, +4126 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes 2 X No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Caucasian 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henrietta Louise Richmond Lewis Thomas Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13458 Villa D'Est, Highland, Maryland 20777 Michael Gerhardt - Son 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 🗓 Burial 2 🗆 Cremation 3 🗓 Removal from State 11/30/2011 Washington, DC Olivet Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses M01564 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 DOW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Weeks Immediate Cause (Final Congestive Heart Failure Priysician/ disease or condition Medical resulting in death) Examiner Arteriosclerotic Cardiovascular Disease 10 Years if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury quentially list our ditions, Examine Due to (or as a consequence of): and and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Petal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 2 X No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? within 24 hours after death.

To the Funeral Director: After this certifical properties of the funeral director, the funeral director director, the funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 X Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2011

State Registrar 30. Name and address of person

Eileen Gemmell.

NOV 2 9 2011

CRNP,

who completed cause of death (Item 23a) (Type, Print)

3160 Gracefield Road, Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 40128 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 11/24/2011 RUTH MAE GAINER 8:45 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Health & Rehabilitation Montgomery Bethesda If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🔀 F Days Hours 01/24/1924 Yrs Director 249-34-9986 87 Usual Residence of Decedent show 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD 1 Yes 2 - No Montgomery Bethesda 10e Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 5721 Grosvenor Lane 20747 USA items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Specify: 3 Widowed 4 X Divorced Completed Black the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 yrs Cashier Federal Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Joe Mickel Leilah Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Gainer/son 2100 Brooks Drive, #116, District Heights, MD 20747 permit. Page 1 and 2 Department of Healt! Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State . Page 1 s 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Ardent Cremation Sv 12/07/2011 Hanover, MD 22. Name and Address of Facility 21. Signature of Funeral Service Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician ompolications disease or condition Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to lot as a consequence on attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Month Year signed by the and be detached for Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ debility 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has autopsy perform 2 🗌 No Yes 25. Was case referred to Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ✓ Natural work' 1 🗌 Yes 2 No ☐ Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionar: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D43121 how an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 605 Maint Street, Laurel, MD 20707 CHOWDHURY, MD;

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2011

32. Registrar's Sig

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
			State of Maryland / Department of Health and Mental Hygiene	40129
			1 - State Registrar Certificate of Death Reg. No. 2011	10127
	Physicia Medic			3. Time of Death
41	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	. 5.4
No. of the last	Francis			place (State or Foreign
	Funeral Director		7.15 - 54 - 57.35 1 M 2 0 F Vrs Months Days Hours Min. (Month, Day, Year)	DO
	E W		Usual Residence of Decedent	0d. Inside City Limits
	arylan a-f sh fied a	Director	Tob. County 10c. City, Town or Location	1 🔏 Yes 2 □ No
	or 28			itry?
	with t	Funeral	5 7107 21th Ave 20783 USA	
	death item			
36	al", or	d by		ack
21215-0036	within 72 hours after death with the Maryland giene then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working	dustry
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lan	should be fill and Mental is marked o	욘		
Maryland	2 should th and M 27 is mar traumat	11	19a. Informant's Name/Relationship (Type, Print) 19b. Mailli. g Address (Street and Number or Rural Route Number, City or Town, State, Zip C	
			Klasar L. Holland - Husband 17107 24 Ave Hyarttsulle 1711) 20a. Method of Disposition Date 20c. Location - City or To	20783
Jore	ge 1 and nt of Heal t: If item		1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place)	1/
Baltimore,	permit. Page 1 Department of Important: If any injury or once.		4 Donation 5 Other (Specify) Metropolitan PSuli 11-22-11 Attanding 21. Signature of Facility 22. Name and Address of Facility	b.A_
Ä	permit Depar Impor any ir		Theresa neal Adams Finer Home PA Aquasion	Mi) 2508
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
	tiysician/		Immediate Cause (Final disease or condition resulting in death)	Onset and Death
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter those yilly Cause (Disease or injury	
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68760	cate b physics the l	edic	d	
89	certifi anding use a	M/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of deliv	
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Ω	ital or urs aft ral Dir illed in			40 d
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the but	edical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated to course of the cause	ause(s) and manner stated.
	To the within To the Comple	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,	Day, Year)
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2	TOP		30. Name and agrees of person who completed cause of death (Item 23a) (Type, Print) 31. Name and agrees of person who completed cause of death (Item 23a) (Type, Print) 32. Name and agrees of person who completed cause of death (Item 23a) (Type, Print) 33. Name and agrees of person who completed cause of death (Item 23a) (Type, Print) 34. If min 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Heart Homes at Bay Ridge Annapolis . Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours 4/15/1923 577-22-5249 **Director** 88 Washington, DC Usual Residence of Decedent 28a-f shov ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Annapolis 1 Yes 2 X No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 933 Edgewood Rd. Apt. 304 21403 Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. tant: If Item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Yes 2 No 1942-1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 □XWidowed 4 □ Divorced Specify White 1945 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Edward M. Hoffman Nellie L. McEwan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Frederick / Sister 1A Queen Victoria Ct., Chester, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, mportant: If 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2011 Kalas Crematory Edgewater, DM any in 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1 Enter the dis Ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shool, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Diamuol disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): burial-transit gug Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ Pregnant at time of death Month Day Year 2 No ed by the a detached f 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 **Completed I** certificate has been si rector, page 2 should i 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law autopsy perform death? Yes 2 No : After this certification of the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident within 24 hours after death

To the Funeral Director. / Investigation 2 No 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier Name and address of person who co beted cause of death (Item 23a) (Type, Punt) lense Ling ANNAPILIS MD 21401 19hHoof-TAYlor CRAP44

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State

Registrar

NOV 2 9 2011

State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 33√ Medical Name (if not institution, give street and number Examiner 4c. County of Death D D **Funeral** Age (In yrs. last birthday If Unde Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year Months 30 1 M 2 Hours Min. 9 Mary Yand Director Yrs ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 903 Noah Winfield Terrace 21409 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married ģ 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced 1 Yes 2 K No Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Medical Technician Health Care Be 17. Father's Name (First, Middle, Last) should be filed and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ည Edward J. Hecker other traumatic Lilla M. Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Nina H. Martin - Sister 903 Winfield Terrace, Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Baltimore Crematory 11/29/2011 Baltimore, MD 21. Signatura of Funeral Service Licen 22. Name and Address of Facility John M. Taylor Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 147 Duke of Gloucester St, Annapolis, MD 21401 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Multi Physician/ Onset and Death stem Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12-months?

1 Yes 2 No
9 Unknown Month Day signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 2 🗌 No 1 \sum Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Division Accident Investigation 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. crtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and to 29d. Date signed (Month, Day, Year) MP2337308 25 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tidewater County Poner RNP Stephanie Dr Annagolis nth, Day, Year) NOV 2 9 2011 32. Registrar's Signature State Registrar A. par

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DHMH 17 Rev 7/2009

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		1 - For State of Marylan Registrar	d / Depa	artment of F	Health a		ental Hygi	_	11 40132
Physic Med		1. Decedent's Name (First, Middle, Last) David Heise						r⊳24, 26	3. Time of Death 10:24 P M
Exam	iner	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center			polis	3		4c. County of Anne	Death Arundel
Funera Directo	_	5. Social Security Number 217-52-4548 6. Sex 1 3 M 2 5 F 62	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth 6/27/16	9 Ma	Birthplace (State or Foreign Country) and
aryland a-f show ified at	Director		y, Town or Lo	cation	Annap	olis			10d. Inside City Limits 1 🛣 Yes 2 □ No
vith the M 23a or 28 st be not		10e. Street and Number 111 Simms Drive		10f. Zip Code	2140)1	10	g. Citizen of Wha	
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates,	1	Vas Decedent of Hi f Yes, specify Cubal	spanic Orig n, Mexican,		fy Yes or No- can, etc.)	14. Race - /	American Indian, White, etc. White
21215-0036 within 72 hours after giene. her than "natural", o	• Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I life. D	lent's Usual Occupa kind of work done d O NOT use retired) r Guide	ation luring most	of working	, I	6b. Kind of Busin	
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last) Richard Edward Heise Jr.					First, Middle, Ma ie Cox	iden Sumame)	
e, Mar and 2 shou Health and tem 27 is n	1	19a. Informant's Name/Relationship (Type, Print) Marjorie Heise - Mother		g Address (Street a Simms Dr,	nd Number Anna	or Rural F poli:	Route Number C S, MD 21	ity or Town, State .401	, Zip Code)
Baltimore, permit. Page 1 and Department of Heal Important: If item: any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ltimor	sition (Name of natory or other place e Cremato			9/2011	Baltimo:	re, MD
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be executed sician and burial-transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	do	515	_				
68 / 60 ertificate be ding physicia se as the bur	Medical	d			_			_	
BOX death cether attented for u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	/			23d. Date of Month	delivery Day Year
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OI VICAL g Physician: er this certific eral director,	: To Be	examiner? Hospital: 1 Inpatient 2 E	R/Outpatient	3 DOA Other	4 LJ Nurs	sing Home	5 Residence	e 6 🗆 Other (S	pecify)_
VISION Control of Attending feer death. Irector: After the function by the function of the fun	Certificate:	1 ✓ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	injury		es 2 🗆 N	10		t and Number or	Rural Route Number,
Hospital of 4 hours at Funeral D ted filled in	Medical C	29a. Certifier (Check 2 Medical Examiner: On the basis of examination	dge, death oc	ccured at the time, o	date and pla	ace, and d	City or Town, S	e) and manner as	stated.
To the within 2 To the comple	1 - 1	only one) 3 Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier	knowledge, de	29c. License r	time, date a	nd place, a	and due to the car	use(s) and manner	as stated.
松人		30. Name and address of person who completed cause of death (Item 2 Dr. Edith Aniedobe 1500 Forest	23a) (Type, Pri C Glen		lver	Sprir	ng, MD	20910	-2011
Sta Registr	re.	31. Date filed (Month, Day, Year) 32. Registrar's Signatu					J, ~ 22		

Alfred Hawking. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11 Alfred Hawkins Jr. $7:01 a^{M}$ 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number Birthplace (State or Foreign Country)
 DC 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Days Months Hours 1 ⊠ M 2 □ F Manth 1 2 y. 1954 DC 56 Yrs. 219-64-2014 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Delafield Place NW 20011 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Gi 1 Yes 2 No Specify: 3 Divorced 4 Divorced Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cab Driver Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Hawkins Sr. Avis Trotter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gayle H. Washington/Sister 1408 Cavendish Drive Silver Spring MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖺 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial 11-28-2011 Suitland, Maryland eral Service Licensee 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th Street NE Washington DC 20017 23a. Part I. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Aspiration Pneumonia (Respiratory Failure) disease or condition resulting in death) Due to (or as a consequence of) <u> Acute Ischemic Stroke</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Li Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alcoholism, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' 2 🖾 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? Accident 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

inding physician use as the burial death certificate be Box 68760 nse atten for u been signed by the should be detached P.0. Records, page 2 has fospital or Attending Physician: The I 4 hours after death. "uneral Director: After this certificate hed filled in by the funeral director, page **Division of Vital**

Physician/

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29a. Certifier

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To the Hospita within 24 hours To the Funeral Completed filled	Medical
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Stat Registra	
DHMH 17 Rev 7/20	009

Charu Maheswary 1500 Forest Glen Road Silver Spring MD 20910 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0068681

29d, Date signed (Month, Day, Year)

11/30/2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40135 = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 25, Physician/ 2011 11:05 pM Nov. MEYNE L HIRSCHBER Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Kensington 3618 Littledale Road, Apt. 105B If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) 316-03-4430 Director 1 M 2 XF 97 July 20, 1914 IL Usual Residence of Decede 28a-f show 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 10c. City, Town or Location 10a. State Director 1 Yes 2 X No MD Kensington Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20895 3618 Littledale Road, Apt. 105B items permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or item ledical Examiner n 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Education Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frances Wexler Charles Lakin 20016 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3101 New Mexico Avenue, NW, Apt. 544, Washington, DC Rona L. Hirschberg/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 29, 2011 20a. Method of Disposition 1 Burial 2x Cremation 3 Removal from State Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Francis Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final Physician/ rue to (or as a consequence of) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of D P the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of use as the burial attending physiciar Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY DISEASE, ATRIAL FIBRIUM with UYes 2 No 3 Probably 4 Honknown DIABETES, HYPERTENSION, ESTEOPOROSIS 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed page 2 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours after death.

To the Funeral Director: Afte

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier (Check

only one)

29b. Signature a

3

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

ANURAdhA

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ARUN, M. D.

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) N6vember 23, 2011 10:50 a M Physician/ Teresa Larue Ott Howard Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Cárroll Westminster Carroll Hospice Dove House 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** NOV 24, Days Hours Year 963 Pennsylvania 1 M 2 K F 47 212-72-7452 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Director Emmitsburg 1 Yes 2 No Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21727 Funeral 224 E. Main Street USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗙 No Baltimore, Maryland 21215-0036 Specify: Specify: white 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Graphics Company Machine Operator 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Leatrice Coe Thomas Ott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) P.O. Box 277, 224 E. Main St, Emmitsburg, MD 21727 Kenneth Howard, husband 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of **Admit**er**F aginationS**or other place) Date 1 Burial 2 X Cremation 3 Removal from State 11/25/2011 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematory . Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 ista Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ u disease or condition resulting in death) monar Medical Due to (or as a consequence of): Examiner 6 h stat Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No

9 Unknown Month Day Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv performed? Yes 2 No death? 2 🗌 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA ည 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death 28a. Date of injury Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my animals. Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 15552

State Registrar

ranke

WASHINGTON

(SUITE 204)

21157

ROAD ~ WESTMINSTER

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826

Registrar's Signature

1 august

HOWARD SAIDNTZ 31. Date filed (Month, Day, Year) NOV 2 8 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 40137 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 19, Neil Dayhoff Hawk 2011 5:24 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Taneytown 3875 Fringer Road If Under 1 Year If Under 24 Hrs. . Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr 28, 1940 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Hours Min. Pennsylvania Director 219-34-0936 71 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director Taneytown Carroll 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 3875 Fringer Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 ☐
If Yes, Give or 1 Never Married 2 Married ģ 2 D Nd 958-Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: white Completed 1962 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surn Dorothy Lee Dayhoff Glen Nelson Hawk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health ar Important: If item 27 is any injury or other trau 3875 Fringer Road, Taneytown, MD 21787 Connie M. Hawk, wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 11/23/2011 Taneytown, MD 4 ☐ Donation 5 ☐ Other (Specify) Grace UCC Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home istary R-136 E Baltimore St, Taneytown, MD 21787 23a. Part 1). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final recrel concer METESTATIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Examine sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No signed by the a g 🗌 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed certificate 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 29b. Signature and title of entifier

31. Date filed (Month, Day, Year)

Mark G. Goldstein

NOV 2 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40

32. Registrar's Signature

Greens

Darke

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29c. License number

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D'0067691

Frederick.

29d. Date signed (Month, Day, Year) 11.21-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-	State Registrar		tificate of De		R	eg. No. 2 (311	40	138	
Physicia		 Decedent's Name (First, Middle, Last) Agnes Louise Lyon Hoffm 	an			2. Date of Deat Novembe		20 ^Y E¶	3. Time of I	P M	
Medi Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			1	y of Death			
		Genesis Healthcare of Waldo 5. Social Security Number 6. Sex 7. Age	rf (In yrs. last birthday)	Waldor If Under 1 Year	f Under 24 Hrs.	8. Date of Birth	Char		lace (State or	Foreign	
Funeral Director		5. Social Security Number 217-86-9020 6. Sex 1 □ M 2 ▼ F 7. Age	96 Yrs.	Months Days	Hours Min.	July 1,	uly 1, 1915 Maryland				
and show	ğ		10c. City, Town or Lo	cation				10	0d. Inside Cit		
Mary 28a-f otifie	Director	MD Charles	Waldorf						1 Yes	X∐ No	
with the 23a or ist be n		10e. Street and Number 4380 Dr. Samuel Mudd Road		10f. Zip Code 20601			10g. Citizen of USA	What Coun	itry ?		
1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Event Armed Forces? 1 Yes 2 If Yes, Give	ver in U.S. 13. \	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)		ce - America ack, White, e			
hours a 'natural dical Ex	Completed	3 Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupat kind of work done du		ing	16b. Kind of E	Business Inc	dustry		
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should be fill and Mental is marked raumatic ev	욘	Joseph Dixon Lyon					Anderso				
h and 7 is m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street ar O Mason Cr					Code) 20601		
and z s Health tem 27 other tra		Russell Hoffman / Son 20a. Method of Disposition	20b. Place of Dispo	osition (Name of		Date Wa.	20c. Location				
rage Tent of nt: If it		1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place 's Cemete		2011	Bryant	own,	Maryla	nd	
permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signature of Funeral Service Licensee M0081		2. Name and Address		ls Fune	ral Hom Charlot	ne, P.	A. 11, MI	20	
physician and the burial-transit	:	Ceque trially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	consequence of):						А		
de th cerific ne ttendig ed or use as	Physician/Medical Examiner	d	2 Fetal death 3	☐ Ectopic pregnancy	1			Date of deliv	-	Year	
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Physician: this certific ral director,	6	1 ☐ Yes 2 No 1 ☐ Inpatie 27. Manner of Death 28a. Date of inju	ent 2 ER/Outpatie	ent 3 🗆 DOA	4 Nursing H	ome 5 Resid			y)		
Attending or death. ector: After by the funer	Certificate:	1 Matural 5 ☐ Pending (Month, Day 2 ☐ Accident Investigation	v, Year) injury	M 1 □	? Yes 2 No	28f. Location (S			ol Poute Num	her	
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To the Hospital or Attend within 24 hours after death To the Funeral Director: completed filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e 3 Certifying Nurse Practioner: To the	xamination and/or inve	estigation, in my opinio	 n. death occurred : 	at the time, date a	ind place, and (due to the ca	ause(s) and ma	anner sta	
To the vithing to the comp		29b. Signature and title of certifier	n	29c. License	8545	-	29d Date sign	ned (Month,	Day, Year)	, 2E	
me		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print) 211/8/9	WER	WACK	CF. Co.	11	2060	12	

Registrar DHMH 17 Rev 7/2009

State

DEC 0 2 2011

11-08924 Kevin Hicks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

icks		1- For State	State of Maryl				Mental Hy	giene	2		4013
al-w-t		Registrar 1. Decedent's Name (First,	Middle Last)	Ce	rtificate of	Death		R. Date of Dea	eg. No.		of Death
Physici I Exami		Kevin Ant	thony Hicks					Month	Day r 27, 2011	073	7 hrs
		4a. Facility Name (if not ins Upper Chesapeal	stitution, give street and n ke Medical Center	umber)	4	b. City, Town, or Lo Bel Air	ocation of Death		4c. County of Harford	Death	
uneral irector	1	5. Social Security Number 094-72-1720	6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	1	rth(MM/DD/YYYY) y 2,1981	9. Birthplace (S Foreign Country) T	
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ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number	railiax			10f. Zip Code		1	0g. Citizen of Wha		∕es 2 🗶 No
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tural"	d b		or Dates:	V	16a. Decedent	's Usual Occupation	n (Give kind of w		Specify: 16b. Kind of Bus		
e. than "na dical Ex	Completed	Elementary/Secondary (0-12) College ((1-4 or 5+)		ost of working life. D ck Driver	O NOT use retire	ed)	Tra	cking	
lygien other the Me	9	17. Father's Name (First, M	liddle, Last)				.Mother's Name	First, Middle, I	Maiden Surname)		
ental F arked event,	B B		J. Hicks					Vercel			
and M 27 is m matic	입	19a. Informant's Name/Rela				Address (Street a					
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nent of nut: II		1 Burial 2 X Crer 4 Donation 5 Qtr	mation 3 Removal f	Tom State	ithsburg			mber 30,	Smithsbu	rg, Mary	Land
Departn Import njury		21. Signature of Funeral S)	22. N Ke	ame and Address o	f Facility ord P.A. I	uneral H	lome		
sician		23a. Part I. Enter the disea	ise, or complications that	M014: caused the death	33 100	6 East Chur	ch Street,	Frederi	ick, Maryla	t Approx	kimate Interva
edical miner	iner	failure. List only one of Immediate Cause (Final di or condition resulting in de Sequentially list conditions if any, leading to immediate cause. Enter Underlying C	sease a. Cardiac Al Due to (or as b. Dilated Ca e Due to (or as	a consequence o						Botto	en Onset and Death
nd transit	l Examiner	(Disease or injury that initial events resulting in death)		a consequence o	f):	-					
sician a urial - 1	ledical	UNPENDED	AMENDED								
24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and itely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/N	IF FEMALE: 23b. Was decedent pregnar past 12 months? 1 Yes 2 No 9	nt in the 1 Live	nant at time of de	2 Fet	al death 3 er (Specify)	Ectopic pregnan	су	23d. Date of o	lelivery Day	Year
signed by t	by Phy	Part II. Other significant of	conditions contributing	to death but not re	esulting in the u	nderlying cause give	en in Part I.	i	obacco use contrib		_
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certificate ector, page	e Co	25. Was case referred to m	nedical			26.Place of	Death (Check or	1 Yes	2[No 1 [✓ Yes	2 No
this ce Il direc	To B	examiner? 1 ✔ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA Ot	her Nursing	Home 5	Residence 6	Other.	
eath. or: After the funera	اغا	27. Manner of Death 1 ✓ Natural 5	Pending (Mont	of Injury h, Dey,Yeer)	28b. Time of In		at Work? 2 s 2 No	28d. Describe I	how injury occurre	d	
within 24 hours after death To the Funeral Director: completely filled in by the	Certificatio	2 Accident 3 Suicide 6 Homicide	Could not be determined (Specify,		ome, farm, stree	t, factory, office buil	ding, etc.	28f. Location (S or Town, S	Street and Number state)	or Rural Route	Number, City
within 24 ho To the Fun completely	Medical (Ing Physician: To the be Il Examiner: On the basis and manner	of examination a							5)
2 1 0	Ĭ	29b. Signature and title of o		au	-	29c. License r O. C. M.			29d. Date signe November 2		Year)
/A E		30. Name and address of p	erson who completed cau	use of death (Item	23a)		_		· .		
M		Carol Allan, MD	Assistant Medical			more Street R	altimore MD	21223			

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 11 per inf. G922 12/20/11 dk
State of Maryland / Department of Health and Mental Hygiene 20 | State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Douglas Martin Ingham November 2011 11:56 P™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1/30/1967 Mary Land Director 218-66-6957 44 Usual Residence of Decedent Page 1 and 2 should be filed within removed then to them 23a or 28a-f show reart if item 27 is marked other than "natural", or items 23a or 28a-f show reart if item 27 is marked other than "natural", or items 25a or 28a-f show reart. If item 27 is marked other than "natural", or items 25a or 28a-f show reart. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 845 Mission Valley Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 Yes 2 No þ Black, White, etc. 1 Never Married 2 😾 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Y Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Electronics Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roger Bowman Ingham Dorothy Bittner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8630 Port Tobacco Rd., La Plata, MD 20646 Diane I. Richardson/ Sister permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 11/26/2011 Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fundadi Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ SERSi disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ph locaca bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami that the death certificate be executed use as the bunal-transit Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Left the cause (s) and manner as stated.

Left the cause (s) and manner stated. 29a. Certifier completed Certifying Ny Se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and line of certifie 30. Name and address of person who combleted cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year,

NOV 2 8 2011

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

2001 Medical Parkway Annapolis, md 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dennis Judy G. November 2011 8:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel FutureCare Chesapeake Arnold 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** L 26,1932 1 X M 2 □ F Months Days Hours Min. (Month 212-28-1177 West Virginia 79 Director April Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis MD 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 707 Fairway Drive 21409 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give 1952 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1954 1 Yes 2 X No Specify: White Completed 3 Divorced 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry Jid bed Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Equipment Owner 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pearl Judy Ada Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Judy / Wife 707 Fairway Drive Annapolis, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If its any injury or ot once. Nov. 22 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Funeral Service Licensee Barranco & Sons, 495 Ritchie Hwy, P.A. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to for as Examiner Sequentially list conditions Examine day hading to immedicause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown n signed by the a lid be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 hknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 100 မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred Director; After 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D53111 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOKIS 2007 TIDEWATER

Registrar
DHMH 17 Rev 7/2009

State

31 Date filed (Month)

Day, Year)

NOV 2 8 2011

11-08876 Isaac Albert Kirk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Death Reg. No.																
Physicia dical Exami		1. Decedent's Name (First, Middle,Last) 2. Da									Month	Date of Death Month Day Year November 25, 2011 3. Time of Oeath 0335 hrs						
\$		Facility Name (if not institution, give street and number) Montgomery General Hospital						4b. City, Town, or Location of Death Olney					4c. County of Death Montgomery					
Funeral Director		5. Social Security Number 579-01-4697		6. Sex 7. Age (In yrs. I		In yrs. last birt		If Under 1 Year Months Day					,	MM/DD/YYYY), 9. Bird Foreig)	PA.	
		Usual Residence of Decedent																
d bow any		10a. State 10b. County 10c. City, Town or Location MD Montgomery Sandy Spring								- 1		e City Limits						
Varylan 28a-f sl d at one	Director	10e. Street and Nu	mber				1	10f. Zip Code					10g. Citizen of What Cour				ntry?	
ith the l 23a or 100tifie	al Dir	17330 Quaker Lane, #E-4 11. Marital Status 12. Was Decedent Ever in U.S.					20860 13. Was Decedent of Hispanic Origin? (Speci					ify Ves or N	United States No- 14. Race - American Indian, Black,				Black	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Marri		arried Armed Forces?			If Ye	If Yes, specify Cuban, Mexican, Puerto Rica					white, etc.				Diagn,	
urs after tural",	db	3 X Widowed 15. Decedent's E		orced If Yes, Give Yeer WWII city only highest grade completed)			1 Yes 2 X No specify: 6a. Decedent's Usual Occupation (Give kind of								Business/Industry			
16 n 72 hor nan "na ical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)					during most of working life. DO NOT use retired											
5-003 ed withi lygiene.	Com	12 17. Father's Name	(First, Middle	Last)			Superintendent 18.Mother's Name (F					Constru First, Middle, Maiden Surname)				tion		
121; Id be fil Mental F narked event, i	To Be	Pinkney Jacob Kirk 19a. Informant's Name/Relationship (Type, Print)					Mailing	Address	Street	Mary		oward Stubbs ral Route Number, City or Town, State, Zip Code)						
MD 2 shou Ith and P is rumatic	۲								well Road, Silve									
Ore, ges lan t of Hea : If iten		20a. Method of Dis 1 Burial 2	of from State crematory or o			her place)							City or Town, State					
altim mit. Pa partmen portant ury or o		4 Donation 5 Other Specify: George 21. Signature of Funeral Service Licensee						ningt me and Ad	ON (Cem.		/2/11 Adelphi, Maryland riel H. Barber Funeral Home						
മ്≗≗∄ Physician	Tr. O. Box 5036, Laytonsville,										MD)	2088					
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Chest Injuries														Between	Onset and Death	
Examiner		or condition resulting in death) Due to (or as a consequence of):																
	Examiner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated																
outed nd ransit		events resulting in death) Last Due to (or as a consequence of): d.																
760, icate be executed physician and the burial - transit	n/Medical	UNPENDED AMENDED																
6876 ertificate ding phy	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth						2 Fetal death 3 Ectopic pregnancy					23d. Date of delivery Month Day				Year	
Attending Physician: The law requires that the death certificate be executed ar death. Teach: Teach: Teach: Teach: The law requires that the death certificate be executed ar death. Teach: Teach: Teach: The law requires that been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transity.	Physicia	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)																
ires that the signed by	ā	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive Atherosclerotic Cardiovascular Disease									23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed										24a. Was an 24b. Were autopsy findings ava prior to completion of caus							
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of Ving Physical After this uneral dir	2	1 Ves 2 No 1 Impatient 2 Erroutpatient 5 DDA 4 Nursing nome 5 Residence										occurred						
Sion Attendi	catio	1 Natural 5 Pending Nov 25, 2011 o 0254 h						1 Yes 2 No				river of auto involved in collision 8f. Location (Street and Number or Rural Route Number, City						
> 2 4 2 1	Certification:	4 Homicide determined (Specify) Major Road / High										or Town, State) i. 108 and Dr. Bird Road, Olney, MD						
Divi	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
F S F S	Me	29b. Signature and		29c. License number O.C.M.E.					29d. Date signed (Month, Day, Year) November 26, 2011				ar)					
		30. Name and address of person who completed cause of death (Item 23a)									14046	14046HIDGI 20, 2011						
1041			Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223															
St Regist	ate trar	31. Date filed (Mon	NOV 3"	2011	Densem		Soci	Kel										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nov. Okyung Kwon 12:24PM 24 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 6. Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 619-23-1054 Days Hours 51 Director Korea Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Ex-miner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a مr 9aa. عام 19 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 21228 10g. Citizen of What Country? 301 Reserve Court Funeral Korea 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Asian Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Music Director Religious Music Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ments. Important: If item 27 is marked any injury or cet. 2 Youngwoo Kwon Dongsoon Kim 19a. Informant's Name/Relationship (Type, Print)
Gui Ok Jeon-Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Reserve Ct., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of Nov 2011, 20c. Location - City or Town, State Fairfax Memorial Funeral Home 1 Burial 2 XCremation 3 Removal from State Fairfax, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fairfax Memorial Funeral Home, 9902 Braddock Rd., Fairfax, VA 22032 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. REFRACTORY VENTRICULAR Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner MYOCARPIAL Examiner if any, leading to immediate cause. Enter Underlying OISGIASE attending physician and for use as the burial-yansit ORONARU To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DSCHE MIC CARDIO MYOPATHI Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Be B 26. Place of Death (Check only one) examiner? P Other: 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Tes 2 🗌 No within 24 hours after death

To the Funeral Director: / Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated entifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated entifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3[29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Piotr Wyrwinski 7600 Carroll Ave., Takoma Park, 20912 Piotr Wyrwinski

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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2011

backet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40144 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 18:45 P M Robert G. Kolker November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Montgomery <u>Shady Grove Adventi</u>st Hospital Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** Hours Month: 578-48-2398 1 ₹ M 2 □ F 73 **Director** Washington DC June 3, 1938 Yrs Usual Residence of Decede or 28a-f shov notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director MG Silver Spring 1X Yes 2 □ No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 20906 U.S.A. 15301 Wallbrook Court #1E 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1958 Black, White, etc. ò 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Distribution Owner permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, the once. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Beatrice Shapiro Sidney Kolker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18108 Carrisa Way, Olney, Maryland 20832 Blaine M. Kolker/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other plac Judean Memorial Gardens 1X Burial 2 Cremation 3 Removal from State or other place. 4 ☐ Conation 5 ☐ Other (Specify) Olney, Maryland 11/27/2011 22. Name and Address of Fandward Sagel Funeral Direction, Inc 21. Signature of Funeral Service Licenses mo 1597 Magneenhat 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Ceath acute myocardia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Chronic renn if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury that initiated events Examine the burial transit The law requires that the death certificate be executed coronary physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? certificate 2 No Yes 2 🗽 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Maryland 20850 Medical Center Drive, William Dooley, 9901 31. Date filed (Month, Day, Year 32. Registrar's Signature State 3 0 2011 NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26,2011 Physician/ Month 6:37 PM Martha Kaufman November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Shanti House Laurel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Day, Year) Hours **Director** 099-05-9060 1 M 2 X F Yrs. 96 11/15/1915 New York Usual Residence of Deceder 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director 1 Yes 2 X No Greenbelt Maryland Prince George's 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 45-K Ridge Road 20770 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other tl 12 U.S. Air Force Benefits Coordinator permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gussie Tarlow Samuel Goodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45-K Ridge Road. Greenbelt. Maryland 20770 Ira Kaufman - Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 🗶 Burial 2 🗆 Cremation 3 🗶 Removal from State King David Mem. Grdns 12/01/2011 | Falls Church, Virginia 4 Donation 5 Qther (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Hypertensive Cardiovascular Disease Years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Drie to for es a nonsequente, off trany keeding to immedicause. Enter Underlying an and Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last nding physician a use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 **X** No
9 ☐ Unknown for Day Month Year the hed 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Hypothroidism Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Assisted 2 X No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death

To the Funeral Director:

Completely filled in by the the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Medical

29a. Certifier

3 [

Raikumar Bhojraj,

NOV 3 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

29b. Signature and title of certifier Ff 8

31. Date filed (Month, Day, Year)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D23181

704 Gorman Avenue, Suite T-1, Laurel, Maryland 20707

November 28, 2011

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

11-09085 Wallace Bruce Keller Please Type or Print in Black State of Maryland

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/ Department of He	ealth and Mental Hygiene	20	l	l	40140

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Physician Medical Examine	er	Decedent's Name (F Wallace)	B.		Ke	ller			Jr	:	2. Date of Dea Month Decembe	Day r 2, 201			3. Time o 1544	
		4a. Facility Name (if no Western Mary							r, Town, or L nberland	ocation of	Death			County of egany	Death		
Funeral Director		5. Social Security Num 220-32-26		Sex X M 2 F	7. Age (In)		thday) Yr:	Mon	nder 1 Year nths Days	If Under Hours	24Hrs, Min.	8. Date of Bi	•	- 1	Foreign	olace (St	
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nd ihow any se.		10a. State 10b	b. County Alle	egany	10c.	City, Town			rland								le City Limits
ith the Maryland 23a or 28a-f show notified at once.		10e. Street and Number		Street S	 F			10f. Z	Zip Code	215	 02	1	0g. Citizer		it Country		
with the 18 23a c. notii		11. Marital Status	TOVICY	12. Was Dec		in U.S.	13. W	as Dece	dent of Hispa		gin? (Specify Yes or No-						Black,
er death with , or items 23 r must be no		1 Never Married 3 Widowed	2 Marri	ed Armed F 1 X Yes ed If Yes, Give Yes	2 🔲 N				cify Cuban, I		Puerto R	ican, etc.)		White, pecify:	etc.		
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y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fain traumatic event, the Medical Examiner must be notified at once TO Re Completed by Firmeral Director	Detail	Elementary/Seconda		College (_	nost of w eant	orking life. [OO NOT u	se retire	d)	Cit	City of Cumberland P		and Po	li ce Dept.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Re Commit	ם מ		ice B. k	Keller, Sr						M	ary	irst, Middle, I Nixon		·			
MD 21 d 2 should th and Me n 27 is ma rumatic en	2	19a. Informant's Name/ Joan Gr		(Type, Print)	compa							ral Route Nur SE Cu			State, Z	ip Code) MD	21502
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Baltimore, pernit. Pages I at Department of He Important: If ite injury or other to		4 Donation 5	Other Speci	fy:		Scarp			al Home			12/6/201		Cres	apto	wn	MD
Bal permi Depar Impo injur		1. Signature of Funeral Service Licensee 22. Name and Address of Facility eral H 108 Virginia Avenu											rland, I	MD 21	1502		
Physician /Medical	1	23a. Part I Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.											est, shock	, or hear	t		mate Interval n Onset and
Examiner		Immediate Cause (Fina or condition resulting in		Due to (or as a		ce of):											Death
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led Insit Examiner	Yell !	cause. Enter Underlying Cause (Dissase or injury that initiated events resulting in death) Last Due to (or as a consequence of):													_		
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b. Box 6i the death cert by the attendii ched for use a		1 Yes 2 No 9		wn 9 Unkno	own			ther (Sp			·						
P.O.	2	Part II. Other significa	nt conditions	s contributing to	death but n	ot resulting	g in the u	underlyir	ng cause giv	en in Part	I.	23e. Did to	bacco use				of death? Unknown
Records, The law requires ficate has been sig.; page 2 should be												24a. Was autop	sy	pri	or to con		ngs available of cause of
The la	5											perfor 1 ✓ Yes	med? 2 No		ath? Yes	2	No No
Ital Recition: The certificate rector, page	3 2	5. Was case referred t examiner?	to medical	Hospital:					26.Place of	hor -							
ing Physician: After this certi uneral director		1 ✓ Yes 2 7. Manner of Death	No	28a. Date		✓ ER/Ou	Itpatient		DOA 28c. Injury			Home 5 3	Residence		Other:		
Division o spital or Attending nours after death. neral Director: After filled in by the fune Certification:		1 Natural 5 Pending Dec 2, 2011 Year) 2 ✓ Accident Investigation 1 1501 hrs 1 Yes 2 ✓ No										river in an	auto to	auto c	ollisior		
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the Ho hin 24 I the Fu																	
To with	2	9b. Signature and title	of certifier	and manner s	tated.			29	9c. License r	number			29d. Dat	e signed	(Month	, Day, Ye	ar)
12.MN		James 9	witha	U, MD					O.C.M.	E.	December 3, 2011						
13 lm	3	0. Name and address of Pamela E. Sou		Assistant I	Medical E	xamine	r 900	W. B	altimore	Street, E	Baltimo	ore, MD 2	1223				
State Registra	е ^З	31. Date filed (Month, Day Yaar) 32. Registrats Signature.															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 11/21/2011 Robert Lombardo 8:32aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bowie Health Center Bowie Prince George Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 029-26-3081 76 **Director** 1 🛛 M 2 🗌 F 7/9/1935 MΑ Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2xxNo MD Prince George Bowie 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 11213 Raging Brook Dr. 20720 items ; Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No 1954-Baltimore, Maryland 21215-0036 1 x x es : 1 ☐ Yes XX No Specify: White 3 Widowed 4 XX ivorced Specify Completed Year or Dates 1957 ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Administrator Catholic University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F and of Health and the tem 27 is marke. ည Salvatore Lombardo Anne McNeil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11213 Raging Brook Dr. James Lombardo Son Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Date ☐ Burial 2 XXCremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/26/2011 Glen Burnie, MD 21. Signature of Funeral Service preseet 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Chronic Obstructive Lung Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 as the l IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3XXProbably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed? 2 No Yes 2 X No 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 2 🔀 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2XXER/Outpatient 3 I DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at injury 1 X Natural 5 Pending Investigation 1 Yes 2 No Acciden
Suicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 31. Date filed (Mon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Cecil George

7219 Hanover Pkwy. Ste. B gistrar's Signature

29c. License number

D58182

Greenbelt, MD 20770

29d. Date signed (Month, Day, Year,

11/21/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 8:05 AM 11 LIAM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL ANNAPOLIS MEDICAL If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth Age (In yrs. last birthday) **Funeral** Month, Day, Ye
/20/192 1 X M 2 □ F Days Min Hours Yrs Director 165-22-5091 84 Pennsylvania Usual Residence of Decede death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 🗆 Yes 2 🕅 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2791 Topmast Court 21401 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirance. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public School System 5+ years Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louise Molnar Andy Bakos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monticello R. Laslo/ Wife 2791 Topmast Ct., Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/27/2011 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Signatu 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final nysician/ ASPIRATION PHEUMONIA disease or condition ONE WEEK Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Pregnant at time of death Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ϵ completed filled in by the funeral director, page 2 should be detached it 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ၉ 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending work? 1 🔲 Yes 2 No Accident
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and thie of certifie 29d. Date signed (Month, Day, Year) 11/24/11 IN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Monti State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GLEN 09:45 M 24 Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death John And ARLOINE MANDRING INPATIENT ANNE ARUNDEL HARWOOD 8. Date of Birth (Month, Day, Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🕅 M 2 🗆 F 70 CALIFORNIA Director Yrs 568-56-0728 05/19/1941 Usual Residence of Decedent 28a-f show 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No ANNAPOLIS MARYLAND ANNE ARUNDEL 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21401 203 FIRST STREET 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 X Divorced Specify: WHITE Completed Year or Dates. 8 YRS and Mental Hygiene.
Is marked other than "natur
aumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FORKLIFT DRIVER RETAIL SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If Important: If Item 27 is marked any injury or other traumaster. ည ESTHER HALL WALTER LENNSTROM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 FIRST STREET ANNAPOLIS, MARYLAND 21401 JUDITH WAGNER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CTAPEAKE CREMATION 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2011 STEVENSVILLE, MD 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS HELFENBEIN & NEWNAM CREMATION 2 FUNERAL CARE P.A. 814 BESTGATE RD ANNAPOLIS, MD 21401 21. Signature of Funeral Service Licenses 231 Fart 1. Enter the discusse, or complications that caused shock, or heart facure. List only one cause on each line. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Day Month Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 D Other (Specify) MANDRIN 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No House after death.

Director: After t Certificate: Hospital or Attending injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) ENEVIEUE MOK 445 Defense Huy, ANNAPOLIS MO 2140, 31. Date filed (Month, Day, Year) NOV 2 8 2011 Registrar

DHMH 17 Rev 7/2009

21215-0036

Maryland

Baltimore,

Box 68760

P.O.

of Vital

Division

40150

			1 - State Registrar	•	Certificate of Death	,	Reg. No.							
	Physicia Medic		1. Decedent's Name (First, Middle, Last) HARRY E.	LEWIS		2. Date of Dea Month	th 3. Time of Death 23 II 10:34p M							
	Examir	er	4a. Facility Name (if not institution, give street an 201 Lockwood Court	d number)	4b. City, Town, or Location of Annapolis	Death	4c. County of Death Anne Arundel							
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	F 7. Age (In yrs, last birthda	Months Days Hours	4 Hrs. 8. Date of Birth Min. 6 Man 1991	9. Birthplace (State or Foreign Marriy Land							
	Maryland 18a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arunde	10c. City, Town or	r Location Annapoli	S	10d. Inside City Limits 1 ☑ yes 2 ☐ No							
	h with the l is 23a or 2 nust be no	Funeral Di	10e. Street and Number 201 Lockwood Court		10f. Zip Code 2140		10g. Citizen of What Country?							
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy figury or other traumatic event, the Medical Examiner must be notified at once.	至	1 ☐ Never Married 2 ☐ Married 1 ☐ 1 ☐ Never Married 2 ☐ Married 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1	b Decedent Ever in U.S. ed Forces? kYes 2 No both No by, Give ror Dates. WWII	13. Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☐ No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White							
Baltimore, Maryland 21215-0036	vithin 72 ho iene. ir than "nat the Medica	Completed	15. Decedent's Education (Specify only highest grade comp	ege (1-4 or 5+) (Gi	ecedent's Usual Occupation five kind of work done during most of a. DO NOT use retired) Supervisor Paint		16b. Kind of Business Industry Painting							
/land ?	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Harry E. Lewis Si		18. Mother	's Name (First, Middle, M	Maiden Surname)							
, Mary	nd 2 should ealth and N m 27 is m a ner trauma		19a. Informant's Name/Relationship (Type, Print, George Miller – Nephe	1	ailing Address (Street and Number 1 West Lake Dr,									
timore	t. Page 1 a tment of H tant; If itel jury or oth		20a. Method of Disposition 1 👿 Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	I from State cemetery, c	sposition (Name of crematory or other place) luff Cemetery 1		20c. Location - City or Town, State Annapolis, MD							
Bal	permit Depar Impor any in		21. Signature of Funeral Service License Licen											
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Approximate Interval Betwoest and Due to (or as a consequence of):											
	ifficate be executed ag physician and as the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or iinjury that Initiated events c.	ue to (or as a consequence of):										
x 68760	as d ≟	ian/Medical		s, outcome of pregnancy Live Birth 2 Fetal death (3 ☐ Ectopic pregnancy		23d. Date of delivery							
O. Box	the deat by the at ached fo	Physician/	1 Ves 2 No 4 4		5 Other (specify)		Month Day Year							
ds, P.(s tha gnec se de	þ	Part II. Other significant conditions contributing	to death but not resulting in th	ne underlying cause given in Part I.		pacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 → Inknown							
Reco	The lav ate has page 2	Completed				24a. Was are autops perform 1 \square Yes	prior to completion of cause of death?							
<u>Ita</u>	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		26. Place of Death									
n of V	iding Phys th. After this funeral di	cate: To	27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpat Date of injury (Month, Day, Year) 28b. Time injury	tient 3 □ DOA 4 □ Nurs e of 28c. Injury at	28d. Describe ho	ence 6 Other (Specify) w injury occurred							
Division of Vital		Il Certificate:	3 Suicide 6 Could not be	Place of Injury - At home, farm, building, etc. (Specify)			reet and Number or Rural Route Number, r, State)							
	the Hospit nin 24 hour the Funera	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
			29b. Signature and title of certifier 29c. License number 29d. Date Signed (Month) Day, Year) 25c. License number 29d. Date Signed (Month) Day, Year)											
	A. 27. x		30. Name and address of person who completed	cause of death (Item 23a) (Type	e, Print) 45 Defense H	uis ANNA	Jackie Mis Z/481							
	Stat Registra	_	31. Date filed (Month, Day, Year) NUV 2 8 2011	32. Negistrar's Signature	beech	/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death NOV. 21, 2011 Physician/ 12:40A M HENRIETTA LUDTKE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner NATIONAL LUTHERAN HOME MONTGOMERY ROCKVILLE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign ial Security Number **Funeral** Year) 917 212=09-4033 94 Months Hours NOV 11 1 🗆 M 2 💢 F MARYLAND **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director MD. MONTGOMERY ROCKVILLE 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 9701 VEIRS DRIVE 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER AT HOME 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHRISTIAN G. ELIZABETH M. TOBALL 2 WOLF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK McGOVERN -EXECUTOR 9701 VEIRS DR, ROCKVILLE, MD. 20850 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place, 1X Burial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 11/28/11 BALTIMORE, MD. 4 Donation 5 Other (Specify) Signature of Funeral Service Lio ne 22. Name and Address of Facility 2222-WISCONSIN AVE., NW HYSONG CO., INC-20007 WASHINGTON, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stage Alzheimers Immediate Cause (Final Ph_sician/ 4PG15 disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions Directo (or se a nontequence of) Examine if ally, leading to himselate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death ed by the a Unknown signed by the signed by the signed si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 00050612 November 21, 2011

State

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 Veirs MAITER 32. Registrar' Signatu e

rive Rockville Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Prepartment of Health and Wental Hygiene For State Registrar Amend#20b. 20c. PerFHPQC12-7-11cr Certificate of Death 2. Date of Death 3. Time of Death Physician/ NOVEMBER JUAN CARLOS GUERRERO LIRA 2011 6:10P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Country) 23 Director <u>Mexi</u>co ugust Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Mexico Funeral 20874 8946 Alliston Hollow Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11 Marital Status Armed Forces? ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: Hispanic If Yes, Give Year or Dates Specify: Mexican Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Agriculture Farming permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tomasa Nira Nira ည Juan Guerrero Rodriguez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8946 Alliston Hollow Way, Gaithersburg, MD 20874 Juan Guerrero Rodriguez/Father 20b. Part copri Municipal De 12-9-2011
Olimpia Gaisada Los Cabos 05/2011 20c. Location - City or Town, State **Baja California Sur,**<u>Mexico City</u>, Mexico 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P. A. 5538 Marlboro Pike, Forestville, MD 20747 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Due to (or s a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): -transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be a thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physicis impleted filled in by the funeral director, page 2 should be detached for use as the burnable. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ntechon autopsy performed? Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes ဂ္ဂ Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or inventionities in accordance in a stated. Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NY 249536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEHA KORDE 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 32. Regis rar's Sig Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ James J. Lupis, Sr. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Allegany WM Regional Medical Center Cumberland 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 5 Social Security Number **Funeral** Country) 4/09/14 1**X** M 2 □ F Hours 97 Director 217-05-0127 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director item 27 is marked other than "natural", or Items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified Ridgeley WV Mineral 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 26753 Rt. 2 Box 653 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status þ 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Pulp & Paper Scheduling & Planner permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygiel Important: If item 27 is marked other any Injury or other traumatic event, thousant. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Teresa Cavallo Vincento J. Lupis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Box 652, Ridgeley, WV 26753 William Lupis/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) St 11/19/11 Keyser, WV Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funeral Home, Inc. 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Abdominal aostic dissection and rupture disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descript at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Day in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Rt pulmonary 1 Tes 2 No 3 Probably 4 Unknown ischenic bowel 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an acute anemia performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

Christopher

ss of person who completed caus

Vagnoni,

S.

,902, Seton Dr.,

in us

ath (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

11-16-11

Cumberland, MD 21502

			FOI	e of Maryland	•			Mental Hygi	ene				
			State Registrar		Cer	tificate of D	eath	1	eg. No. 20	40151			
	Physicia		Decedent's Name (First, Middle, Last) Dorothy	Eileen L	orentz			2. Date of Death Decembe	Day Va	3. Time of Death ar 2100 PM			
\$	Medic Examir		4a. Facility Name (if not institution, give street and		.01 01101	4b. City, Town, or	Location of Death		4c. County of D				
1,94			3907 Spanish Bay Cour	t		E1ktor			Ceci	L			
	Funeral Director		5. Social Security Number 141−36−6563 6. Sex 1 □ M 2 □ M	7. Age (In yrs. Ia 66	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 26,	year) 1945 g.	Birthplace (State or Foreign Country) York			
	nd how	ŗ	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	eation				10d. Inside City Limits			
	faryla 3a-f s tified	Funeral Director	Pennsylvania Lehigh	A	11ento	wn				1 ☐ Yes 2 ☐ No			
	the N	ΙDir	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What	Country?			
	h with 1s 23a nust b	nera	650 East Lexington St	reet		18103	3		United	United States			
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fledical Examiner must be notified at.	by	1 Never Married 2 Married 1 If Yes,		"	Vas Decedent of Hi Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- o Rican, etc.)	Black, W	American Indian, Vhite, etc. Vhite			
Maryland 21215-0036	hours natura ical E	Completed	15. Decedent's Education	r Dates.	16a. Deced	ent's Usual Occupa	ation	- 1	16b. Kind of Busine				
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7	ygien ygien her th	Be Co	1	,	Yo	uth Couns			Correction				
and	ntal H ed ot ever	To B	17. Father's Name (First, Middle, Last) Harry Edward Earl					ne (First, Middle, M	•				
Ž	ould k nd Me mark matic		19a. Informant's Name/Relationship (Type, Print)		19h Mailin	a Address (Street a		y Jean 0		Fown, State, Zip Code)			
, Ma	nd 2 sh salth ar n 27 is er trau		Virginia A. Lorentz/Da	1921									
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, <u>the Medical Exar</u> once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Anatomy Gift Registry 2011 20c. Location - City or cemetery, crematory or other place) Anatomy Gift Registry 2011										
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	for Fune Elkton,	erals, F.A.								
			23a. Part 1. Enter the disease, or complications the		n. Do not ente					Approximate			
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	and transi	Examiner	Cause (Disease or iinjury that initiated events c.	to (or as a conseque	0000 00:								
0	be executed sician and burial-transit	dical E	resulting in death) Last Due	to (or as a consequ	ence oi).								
3760	ficate g physas the		- a										
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes. 2	23d. Date of Month	23d. Date of delivery Month Day Year								
P.O.	that th	y Ph	Part II. Other significant conditions contributing	to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribut	e to the cause of death?			
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Division of Vital Records,	he law rec te has bee age 2 sho	omplet	PRIOR SMOKIN	16				24a. Was an autops perform	y prior ned? deat				
a	ian: T	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (Chec						
Ξ	hysic this ce	유	1 Yes 2 Hospital:	☐ Inpatient 2 ☐ I			4 L Nursing H	ome 5 Resider	nce 6 Other (S	Daughter's Residence			
n of	ding P h. After 1 funera	ate:	1 Natural 5 Pending	ate of injury Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆		28d. Describe hov	v injury occurred				
Siol	Attend r deatl cctor: by the	rtific	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			Rural Route Number,							
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	e Hospital or Attending is 24 hours after death. 9 Funeral Director: After leted filled in by the funer	Medical Certificate:	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the 3 Certifying Nurse Praction	basis of examination	and/or invest	igation, in my opinio	n, death occurred	at the time, date and	d place, and due to t	the cause(s) and manner stated			
	To the within 2 To the comple	2	29b. Signature and title of certifier		Miowicago, c	29c. License			9d. Date signed (M				
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	Tan		- w // 1	cause of death (Item		ririty		04100	RID!	19702 MGU/ADIC 176			
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	Registr		BEC 1 4 2011 Denna	P. A.	The same of the sa								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per med cert G922 12/2//11 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Florence J. Marston 11:12 A M Nov. 26 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Davs Hours Min Director 1 □ M 2 🏋 F 106 09 1997 96 Yrs Aug 9, 1915 Buffalo, NY Usual Residence of Decede show 10a. State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ems 23a or r must be i Funeral 7309 Roselynn Lane 20735 <u>United States</u> er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status rmed Forces?

Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give WWIII Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 🙀 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) 12 College (1-4 or 5+) Womans Airforse Service Pilot-WASP U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Niemiec Minnie Niemiec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Morrill E. Marston, Jr. (Son) 1172 N. Pitt Street, Alexandria, Va 22314 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cemetery (unk) Arlington, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 this certificate has performed Yes 2 X N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 Tyes 2 40 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SANIBORMU 26 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Durratts Road, Clinton, CHMOAIGHE SUDHEER 31. Date filed (Month, egistrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14151 3:50 p M HAMAS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Social Security Number Under 24 Hrs. 8. Date of Birth (Month, Day, Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Days 1 X M 2 . F 76 Maryland Director 20-34-1935 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director Mary and 10e. Street and Number 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 20613 453 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. or other traumatic event, the Medical Examiner Armed Forces Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 ☐ Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Malcle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or ural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Juneral Service Licensee 22. Name and dress of Facility 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEASE ARTER ORONARY Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ELTENSION Securations list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin burial-transi Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 I Inknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à EMENTIA Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2.XNo Other: 1 🗌 Yes ည After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation Funeral Director: sted filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signatu and title of certifie 29d. Date signed (Month, Day, Year) 3885 2011 who completed cause of death (Item 3a) (Type, Print) Name and address of person 20602 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ NOVEMADE 26 Charles Eugene McCarthy, Jr. 0320 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARFORD HAURE .DE HARFORD MEMORIAZ HOSPITAZ GRACE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) Feb. 25, 1924 Days 1 x M 2 □ F 214-20-0733 Maryland Director 87 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Perryville Maryland Ceci1 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21903 Funeral U.S.A. 24 Gilley Road 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. 1 Never Married 2 K Married ģ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Year or Dates. 1943-46 3 Widowed 4 Divorced White Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Penn Central marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Engineer Railroad Twelve Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Eugene McCarthy, Sr. Mary Alice Campbell permit. Page 1 and 2 shoul Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
428 Reservoir Road, Perryville, Maryland 21903 Kathleen A. Creswell 20a. Method of Disposition 20c. Location - City or Town, State Port Deposit, 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Asbury Cemetery 11/30/11 4 Donation 5 Other (Specify) Maryland 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Sign vure of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CONGESTIVE HEAR? FAILURG disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** CARNIOMYOPATIN ISCHEMIC. Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) CORONART and bunial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the ! M & CArthy, Charks Eugh Division of Vital Records, P.O. Box 68766 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Day 2 No Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed' or Attending Physician: The 1 🗆 Yes 2 🗷 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined e Hospital of 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hou

To the Fune

completed file Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) ATTONDING NOVEMBER 27 2006223 PHYSICIAN. DR MAW NAING OO, HD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4+1VA MOMORIA HAVRE DE GRACZ 1725AIZAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40158 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rebecca Weeks Murashige 1450 M NOU Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 414 Riggs Avenue Severna Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 063-44-7361 **Director** 1 M 2 XF 60 Aug. 28,1951 New York or 28a-f show notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral 414 Riggs Avenue 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give within 72 hours after White 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of ပ William Weeks Mary Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Glenn Murashige / Husband 414 Riggs Avenue Severna Park, MD 21146 Page 1 and 2 Date 21, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Nov. Metro Crematory, Baltimore, MD 4 Donation 5 Other (Specify) INC. 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Trteriosclerotic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical death certificate be the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 2 No 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier eput 4 Name and address of person who completed cause of death (Item 23a) (Type, Print) ones State Registrar

DHMH 17 Rev 06-2011

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month // Physician/ Day 22 5:35 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FAIRFIELD NURSING & REHABILITATION CROWNSVILLE ANNE ARUNDEL 8. Date of Birth Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F Hours 01/13/1937 MARYLAND Director 216-34-3926 74 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1018 BOOM COURT 21401 USA 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. rces? 2 No 1958-e UNK Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Yes. Give 3 Divorced Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTANT ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ PHILIP E. MCKENNA, SR. DOROTHY HORTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN MCKENNA/WIFE 1018 BOOM COURT, ANNAPOLIS, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 CROWSVILLE VETERANS 1 N Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2011 CROWNSVILLE, MD 21. Signature of Funeral Service Licenses - Manuel J 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Priysician/ disease or condition pa Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Pregnant at time of death Day 1 ☐ Yes 2 ☐ Unknown Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Funeral Director: After this certificate has mpleted filled in by the funeral director, page 2 perform Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 1 ANatural 5 Pending 2 Accident
3 Suicide death. 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 10 leted cause of death (Item 23a) (Type, Print) ANNAPOLIS Defense 445 Date filed (Month, Day, Year, State NOV 28

Registrar

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			For State Registrar		State of M	laryland		artment of F tificate of L		Mental Hy	giene Reg. No			40	160)
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200	Examir	er	4a. Facility Name (if Lorien Nu		e street and number)	4b. City, Town, or Location of Death Columbia						4c. County of Death Howard				
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9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	þ	11. Marital Status 1 □ Never Marri 3 ፟፟ Widowed		12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.		l1	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		14. Race Black Specify:	etc.			
Baltimore, Maryland 21215-0036	ithin 72 hou ene. r than "natu the Medica	Completed	(Special Special Speci	15. Decedent's E cify only highest gr onday (0-12)		5+)	(Give H	ent's Usual Occup kind of work done of NOT use retired) e chnicia	during most of w	rorking	16b. Kind of Business Industry Dept. of Agrecult			ture		
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Ball	permit Depart Impor any in			1. Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Fune												
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09	tte be executed hysician and he burial-transi	dical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1										_			
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical										*	Year			
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ion of	tending Peath. or: After the funera	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide	5 Pending Investigatio 6 Could not be			28b. Time of injury	28c. Injur work M 1 🗆		28d. Describe h	now injur	y occurred	d .			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#19boerFH22/2/11; BMW, MoCo Certificate of Death Reg. No. 2 I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 25, 2011 Eleanor Μ. Morel 18:41P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5225 Pooks Hill Road, #424N Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) 96 Yrs. If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 T Months Days Director 082-01-2017 April 1^{Pay}30°, 1915 New York, NY Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director Maryland Montogmery Bethesda 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5225 Pooks Hill Road, #424N 20814 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 1 and 2 should be filed with f Health and Mental Hygien ttem 27 is marked other th Manager NY City Housing Auth. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Tillie Stern Samuel Mogul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Agress Tretand Number or Rural Route Number, City or Town, State, Zip Code; 3903 Jenniter Street, N.W. Washington, DC Phyllis Greenberger -daughter 20015 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Montefiore Cametery Page 1 ¿ 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2011 Pinelawn, New York Signature of Funeral Service/Licenses Bonald V: Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ Anorexia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Parkinson's Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 X No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Decubitis Ulcer Hospital or Attending Physician: The law requires 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu 1 Yes Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D20256 November 28, 2011 Migerita Wheaton 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Wheaton, M.D. 1145 19th St., N.W., #800 Washington, DC 20036 31. Date filed (Month, Day, Year) NOV 2 9 2011 . Registrar's Signatu State barles

Registrar

Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Allan November 23, 2011 6:45A. Joseph Monaghan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hillhaven Assisted Ivg. Nursing & Rehab Center Adelphi Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 577-50-4407 1**∑** M 2 □ F Mayonth Day, Ye Scotland **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Prince George's Adelphi 1 🗆 Yes 2 🏖 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10314 Geranium Avenue 20783 Scotland Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White If Yes, Give Year or Dates Specify 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mail Clerk British Embassy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) d 2 should be file alth and Mental H 27 is marked of 2 Martin Monaghan Catherine Carrigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar. Important: If item 27 is any injury or or Edna M. Monaghan -wife 10314 Geranium Avenue Adelphi, Maryland 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 11/26/2011 4 ☐ Donation 5 ☐ Other (Specifit) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service License DentaldowydreBoffewardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ embro rascula disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hypartunsion that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Dav Year as been signed by the a should be detached 9 Unknown 9 Unknown Part II. **Qther significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and 10 of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date file (Month, Day, Year)

NOV 2 9 2011

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

#216 ROCKVILLO MD

701 Pandolph

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Grace A. Miller 2011 12:30 a^M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Jan 11, 9. Birthplace (State or Foreign Country) Maryland . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 214-28-5330 1919 **Director** 1 🗆 M 2 🗙 F 92 Yrs Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10a. State 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director Keymar 1 Yes 2 No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 21757 or items 23a 919 Francis Scott Key Hwy USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Clothing Factory Seamstress Be be filed \ Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Georg ည Christian Margraff injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 64 Maple Avenue, Littlestown, PA 17340 Linda Nickles, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Middleburg, MD Mt. Union Lutheran 12/01/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CLEBROVA Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼ No Year Month 5 Other (specify) Pregnant at time of death ☐ Pregnam. ☐ Unknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate has page 2 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ြို 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 \(\subseteq \text{Yes} 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After iniury X Natural 5 Pending Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely

23,201

NOVEMBER

MILLER

GRACE

State Registrar

only one 29b. Signature and title of

30. Name and address of person

31. Date filed (Month, Day, Year)

JONES,

NOV 28

2300 DULANEY VALLEY RD.

who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

CRNP

29d. Date signed (Month, Day, Year)

MD 21093

TIMONIUM.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Morjaria Surendra D. 2:05p 2011 Nov. 20. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster 2617 Manchester Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Min. 1 M 2 □ F 63 213-76-7549 3/8/1948 Mombasa Kenya Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examinating must be notified at once. 1 ☐ Yes 2 ☐ XNo Director MD Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 USA 2617 Manchester Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □Yes 2 □No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🔀 No Specify. SpecifyAsian Indian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) physician medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dayalal Morjaria Kanchanben (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2617 Manchester Road, Westminster, MD 21157 Bharati Morjaria, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 11/22/11 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline funeral Home M00741 934 S. Main St., Hampstead, MD 21074 Kenn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) yours **Physician** (ancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) cate has been signed by the page 2 should be detached it ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐Yes 2 ☐ No 1 □Yes r Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No he Funeral Director After this relating in by the funeral Director. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Destininstes Batish Shah 826 Washigh 31. Date filed (Month, Day, 32. Registrar's Signature State NOV 2 2 2011 Registrar Backs

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Day 55 PM 04 2011 Decembe Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HEATH WASHAUGTON CENTER ERSTOWN 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) last birthday) **Funeral** Hours 1 M 2 M 48 340 Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No FRANKLI SHIPPENSBURG 10g. Citizen of What Country? Funeral 1725 U.S.A . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ō 1 Never Married 2 Married Completed by 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: LUHZTE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME <u>HOMEMAKE</u>? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 욘 MANNZHY. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S HEPPENSBURG ROBERT C. MOWERY SPOUSE 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 12-8-2011 CHAMBERSBURG 4 Donation 5 Other (Specify) 21. Signalii of Funeral Service Lic 22. Name and Address of Facility FOCELSWGER - TSECKER F. W. DVC. MO1346 ST. SHIPPENSBURG. PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical r as a consequence of): Examine Sequentially list conditions, cause (Disease or iinjury that initiated events ending physician and use as the burial-transi Julino resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Yes 2 No 1 Yes 2 L 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🍎 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🔀 No 욛 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural iniury 5 Pending 1 Yes 2 No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 12/05/2011 15 gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Campis Rd. Hageistown, MD OSkaw 11116

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

4 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40166 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ogay Month 20**1**1 5:00 AM Paul Junior Martin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Mt. Savage 14611 Mt. Savage Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 M 2 □ F Yrs. 84 Director 216-22-5988 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, the Wedical Examinar must be notified at 1 ☐ Yes 2 XNo Director MD Allegany Mt. Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21545 U.S.A. 14611 Mt. Savage Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Des 2 No 945 If Yes, Give Year or Dates: 1951 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No \$ Specify: Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tire Manufacturing Kelly Springfield Tire permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 is marked other i any injury or other traumatic event, II! 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Scott Martin Paul Webster Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14611 Mt. Savage Road Mt. Savage, MD 21545 Son Bradford Martin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Restlawn Mem Gardens | 12-12-2011 | Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.a. Man Dow es? <u>60 W. Main Street Frostburg, MD 2153</u>2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardio vascular disease or condition resulting in death) Atheroscleration 2 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2X No 1 ☐ Yes 2 No 1 □ Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending after death investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide າ 24 hours af າe Funeral ເ Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nonsoch Shin MD 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCKSHIN BIShop 32. Registrar's sign Registrar

11-08567 Eugene Newman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3		1- For State Registrar	Certificate of		_	g. No.	
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		Southern Maryland Hospital		Clinton		Prince George'	
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	n(MM/DD/YYYY) 9. Birth Foreign	
Director		215-72-2934 1XM 2	F 49 Yrs		11-1-	1962 Cou	ntry) Maryland
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ages I and 2 s nt of Health a t: If item 27		20a. Method of Disposition 1 X Burial 2 Cremation 3 Ren		ition (Name of cemetery,	Date	20c. Location - City or T	own, State
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	-1	21. Signature of Funeral Service Licensee		Name and Address of Facility	ıl d	2 1	<i>4</i> , 2 -
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the satter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	ρ Q				1 Yes	2 V No 3 Proba	ably 4 Unknown
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n of ding Pl h. After funera		27. Manner of Death 1 Natural 5 Pending	a. Date of Injury 28b. Time of I (Month, Day, Year) ov 14, 2011 1921 hrs			ow injury occurred ruck by vehicle	
Sio	<u> </u>	2 Accident Investigation	e. Place of Injury - At home, farm, stre		28f. Location (St	reet and Number or Rura	al Route Number, City
Div	Certification:	Suicide Could not be	pecify) Major Road / Highway		or Town, Sta		
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Fuoeral Director: After this certificate completely filled in by the funeral director, page	_	20a Cartifier	the best of my knowledge, death occur	red at the time, date and place, and	due to the cause	(s) and manner as stated	d.
To the within To the comple	Medical	and ma	basis of examination and/or investigatener stated.		at the time, date a		
	≊	29b. Signature and title of certifier	Λ	29c. License number		29d. Date signed (Mont	
		(Mutulell	(4)	O.C.M.E.		November 15, 20	
5 DC.		Name and address of person who complete Laron Locke MD. Assistant M	ed cause of death (Item 23a) edical Examiner 900 W. Ba	altimore Street, Baltimore. I	MD 21223		
Sta	ite	31. Date filed (Month, Day, Year) 2011	32. Registrar's Signature				
Registr	аг	NUV 30 2011	Leneva S. pa	Med			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 24, 2011 Carol Norfolk 1:52 PM_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 3 (Manth 10) 4 Year) **Funeral** 1 🗆 M 2 😿 F 176-34-9615 67 Pennsylvania Director Yrs. Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Annapolis Maryland Anne Arundel 1 X Yes 2 □ No 10e. Street and Number 12 Silverwood Circle 10f. Zip Code 10g. Citizen of What Country? 21403 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give þ 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jane Bodle Kenneth Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 922 Milmada Drive, La Canada, CA 91011 Allison Laskey - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Lakemont Mem Gardens 11/28/2011 Davidsonville, MD Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ STSTOLIL disease or condition 1225 OUL Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause F to Undergo Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed COPI SEVERE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) Dr. Kanak Patel 2001 Medical Parkway Annapolis, Maryland 31. Date filed (Month, 32. Registrar's Signature State NOV 2 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 () | | State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate Of Death Reg. No.														
Physician Medical Examina	1/	1. Decedent's Name (First, Midd	_{le,Last)} arence 0 l	Nixon	Sr.						. Date of De Month Novembe	ath Day er 26, 201	Year I1	3	3. Time of Death 1243 hrs	
		4a. Facility Name (if not institution Prince George's Gene	on, give street and n			4	b. City, To Cheve		ocation of	Death			ounty of D		3	
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birth	day)	If Under		If Under		8. Date of B	irth(MM/DD/		reign	place (State or	
Director	1	230-68-4067	1 M 2 F	61		Yrs.	Months	Days	Hours	Min.	Oct. :	14, 19		Cour	try. Virginia	
any	-	Usual Residence of Decedent 10a. State 10b. County		1100	. City, Town o	Location	on								0d. Inside City Limits	
E			e George		,,			Se	at P	1eas	ant				1 X Yes 2 No	
Maryland 28a-f show	ဥ္ကုန	Maryland Princ 10e. Street and Number	e deorge				10f. Zip 0			2000		10g. Citizen	of What	Countr	y?	
3a or 2	5	510 70th Place	e						2074				nited			
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 X M	12. Was De		er in U.S.		Deceden es, specify				cify Yes or N ican, etc.)	lo- 14.	. Race - A White, e		an Indian, Black,	
ter dea			1 Yes	2 ear	No	1	Yes 2	X No	specify:			Sp		ric mer	an ican	
ours af	<u>8</u>	15. Decedent's Education (Spe	or Dates:		ted) 16a. D	ecedent	's Usual O	ccupatio	on (Give ki	ind of wo	rk done d)	16b. Kind	of Busin		200.0	
n 72 h	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)							•		16 5	7	1	
21215-0036 ald be filed within 7 Mental Hygiene Hygiene event, the Medica	Ę-	17. Father's Name (First, Middle	, Last)	- <u> </u>			ВОО	t B1		s Name (F	irst, Middle	, Maiden Su	:1f-E: rname)	mpı	oyea	
215 be file ontal H.	8	Walter Riddick Lois Nixon														
D 21 should and Me]≏	19a. Informant's Name/Relations Shirley L. Nix					Address 0th					umber, City o				
and 2 sho and 2 sho fealth and tem 27 is	ł	20a. Method of Disposition	OII - WITE	-	20b. Place of	Disposi	tion (Name		etery,		Date				own, State	
nore	d	1 Burial 2 Crematio 4 Donation 5 Other S	_	from State	Natio		er place)	tarv		Dec. 2	011	-				
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other fraumatic event, the Medical Examiner must be notified at once.		21. Si e of Funeral Service		t.	Natio		ame and A			Ste	wart]	Funera		_		
	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart												DC T	20019 Approximate Interval	
/ Physician /Medical	1	failure. List only one cause	failure. List only one cause on each line.												Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as			<u> </u>	o racoun	a. 3 .00								
	<u>ا</u> ة	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequ	ence of):			-						1		
	틽	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):			_	_					-		
cuted and transit	n/Medical Examiner	events resulting in death) cast	d													
Vital Records, P.O. Box 68760, stieins: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit.		UNPENDED	AMENDED					_				Loon F	ate of de	lives.		
8760, tificate be ng physic as the bur	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?			of pregnancy 2	Fet	tai death	3	Ectopic	pregnan	су		onth	Da	ay Year	
Box 68 ne death certi the attendin ned for use a	Physicia		oknown	gnant at tim nown	e of death 5	Oth	ner (Speci	fy)								
C. B.		Part II. Other significant condi			ut not resulting	in the u	nderlying	cause gi	ven in Pa	rt I.	23e. Did	tobacco use	e contribu	te to th	ne cause of death?	
res tha signed be det	Completed by				<u>-</u>										ibly 4 🗸 Unknown	
w requi			<u>.</u>									is an opsy formed?		r to co	opsy findings available empletion of cause of	
Recorded the second of the sec	Ĕ						_				1 Yes	2 No		Yes	2 No	
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ing Phys After thi	잂	1 Yes 2 No 27. Manner of Death	28a. Da	te of Injury		ime of I		-3Y/	at Work		_	e how injury	1			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or T										(Street and , State)	Number	or Rur	al Route Number, City	
Hospita 4 hours funera ely fille													d.			
O the ordina 2 ordina 2 omplet	Medical	one) 2 Medical Ex	aminer:On the basi and manner	s of examin	ation and/or in	vestigat	tion, in my	opinion,	death oc	curred at	the time, da	te and place	e, and due	to the	cause(s)	
H S H S	ž	29b. Signature and title of certif	ier //	W.			290.	O.C.N	number				ite signed mber 27		th, Day, Year) 11	
10		30. Name and address of person	lassey, 1	IIIse of door	th (Item 22a)			U.U.IN	· · · ·			1,40461		., 20		
-81		30. Name and address of person Melissa Brassell, MD				900 W	/. Baltim	ore St	reet, B	altimor	e, MD 21	223				
Sta		31. Date filed Month, Day Year	32.	Registrar	Signature	Les of							-		-	
Registr	rar	man A Managa	hall the way	Jes.	The state of	-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Nicknadavich LOVEMber 0543A M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctors Community Hospital Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) March 22 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 X F Hours 232-09-9616 92 Yrs Director 1919 Charleroi, PA March Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified once. Marvland Prince George's Bladensburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5027 57th Avenue, #203 20710 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mining 8 Coal Miner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tillie Thomas Joseph Nicknadavich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Nicknadavich / Wife 5027 57th Avenue, #203, Bladensburg, MD 20710 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/29/2011 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Gasch's Funeral Home, P.A. Hyattsville, MD 20781 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PULMONARY EMBOLISM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL BAILURE 1 Yes 2 No 3 Probably 4 Completed s been si should 24b. Were autopsy findings available prior to completion of cause of death? PNEUMONIA 24a Was an has e 2 certificate ha performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 🗌 Yes After this c funeral dire မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident neral Director: / Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Pragtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0PE 3200C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESHKUMAR MUTTATH, STIL SARVIS AVE. SUITE 200 RIVERDALE MY 20737

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Vavembe 4:30 PM 2011 Carol Lee Phipps Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Hartor Home Lira ce 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. Months Hours June 27 Year 944 Maryland 218-40-7701 67 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland at Director or 28a-f s notified Cecil Port Deposit 1 🗌 Yes 2 🏻 No Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Funeral 21904 23a U.S.A. 288 Jackson Park Road items r death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Examiner Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates White Specify: "natural", 3 ₩ Widowed 4 Divorced Completed er than "natur, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Personal Residence Nine Years Homemaker it. Page 1 and 2 should be filed wi riment of Health and Mental Hygik ritant: If item 27 is marked other njury or other traumatic event, il is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ethel Irene Sharon James Herbert Reeves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 Conowingo Road, Conowingo, Maryland 21918 Steven Burns Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 ₭ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/02/11 Elkton, Maryland Union Cemetery injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen, ee any in 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ canin disease or condition resulting in death) Medical Due to (as a consequence of): Examiner 6hshruhu-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): dentension death certificate be executed the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (of as a consequence of): physician Physician/Medical Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Year Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Munknown Records, Were autopsy findings available prior to completion of cause of 24a. Was an tor: After this certificate has the funeral director, page 2 s autopsy perform death? 2 **N**o i 🗌 Yes on of Vital 25. Was case referred to medical examiner? Be 26. Place of Deatly (Check only one) 2 🗹 No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 No Accident Investigation 24 hours after deal Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 WN 115WPSIM 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Aro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) November $^{Day}_{22}$, Physician/ 2011 4:44 P Frank Colby Pethel, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral Director** 1 🗆 M 2 🗓 F 81 241-38-3003 March 16,1930 North Carolina Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City. Town or Location 10h. County must be notified at Director 1 🗌 Yes 2 🔽 No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ò permit, Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by Funeral USA 21401 2928 Southwater Point Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Consulting Professional Engineer years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Josie Kathleen Correll Frank Colby Pethel, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2928 Southwater Point Dr., Annapolis, MD 21401 Betty D. Pethel/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/26/11 Kalas Crematory Edgewater, Maryland 4 Dopetion 5 Other (Specify) 21. Sign tree Function Spring Censes 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ARTERY COROWARY Visease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of cancer 24a. Was an LUNG autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 death? 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA ပ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and itle of certifier 9838 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis, Uld. 2140, 2003 Medical MO

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Mor

32. Registrar's Signature

			1 - For State RegistraMEND#200+coerFH,	State of Marylan .12/6/11:BMW.McO	•	tificate of E			ene g. No [*]			
Ph	ysicia	ın/	Decedent's Name (First, Middle, Last)					2. Date of Death	3 201	3. Time of Death		
	Medio xamin		Ruby M. Park 4a. Facility Name (if not institution, give str			4b. City, Town, or	Location of Death		4c. County of I			
- A			Heartland Health			Hyattsv			Prince George's			
Dire	neral ector		5. Social Security Number 417-24-2099 Usual Residence of Decedent	M 2 🗓 F 87	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 12 3 I 1	923	Birthplace (State or Foreign Country) AL		
and	dat	tor	10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits		
Mary	otifie	irec	DC	Was	hingto	7				1 🛣 Yes 2 □ No		
with the	ust be n	Funeral Director	10e. Street and Number 409 T. St. NW			10f. Zip Code 20001			g. Citizen of Wha	t Country?		
Z1Z15-UU36 within 72 hours after death with the Maryland gione.	so other than I have a full terms as of coart show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 및 Widowed 4 □ Divorced	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	If	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc. 31ack		
within 72 hours after giene.	Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	cation completed) College (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done d ONOT use retired)	ation during most of worki	ng 1	6b. Kind of Busin	b. Kind of Business Industry		
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Marylan should be file and Mental	auma'		19a. Informant's Name/Relationship (Type	*		-	and Number or Rura			, Zip Code)		
re, N 1 and 2 f Health item 27	other tr		20a. Method of Disposition	ckett/Daughte	lace of Dispos	sition (Name of				v or Town. State		
baltimore, Marylar per iit. Page 1 and 2 should be f Department of Health and Menta Interpret If from 97 is marked	jury or		1 ☑ Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State ROE	ketOree yland	KonCemete National	⊉y G e 12/02	:/2011 L		110		
Derai Derai	any ir		21. Signature of Funeral Service Licenson				s of Facility Mar t. NW Was					
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	ched for use as the burial transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	c. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of do 9 Unknown	death 3	Ectopic pregnancy Other (specify)	у		23d. Date o Month	f delivery Day Year		
do, F.O quires that the series of signed by	uld be deta	۾	Part II. Other significant conditions contr	ibuting to death but not resu	Ilting in the ur	derlying cause give	en in Part I.			e to the cause of death?		
The law requires	funeral director, page 2 sho	Completed						24a. Was an autopsy performe	prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No		
sician: certific	rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	spital:		Othe	ace of Death (Check	only one)				
g Physical this	neral d	te:	27. Manner of Death		28b. Time of	3 L DOA 28c. Injury	4 Nursing Hor	me 5 Residence 8d. Describe how		pecify)		
tendin leath. or: Aft	the fur	Certificate:	1	(Month, Day, Year)	injury	M 1 □	Yes 2 No					
al or Att	ed in by		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office	1	28f. Location (Stree City or Town, S		Rural Route Number,		
the Hospit nin 24 hour the Funera	pleted fille	Medical	only one) 3 L. Certifying Nurse P	the time, date and p e, and due to the ca	place, and due to t	the cause(s) and manner stated.						
To t	54		29b. Signature and vitle of certifier 20. Name and address of person who compared to the second state of			29c. License	1978	290	d. Date signed (M			
			20. Name and address of person who com	pleted cause of death (Item :	23a) (Type, Pr	Ann	of slis	CML	6)en1	Dale MD 20769		
Re	Stat gistra	e Ir	31. Date filed (Month, Day, Year) NOV 2 9 2011	32. Registrar's Signate	fact	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | | for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Richard Parham Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Allegany 4b. City, Town, or Location of Death **Examiner** Cumberland Western Maryland Health System . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Months OT729/1959 MD 52 219-74-8639 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 🗌 No Cumberland MD Allegany 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral USA 21502 54 Elm St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Towing Truck Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sylvia Deavers Charles Parham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Fairview Ave., Taneytown, MD 21787 Travis Parham/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/28/2011 Hampstead, MD Carroll Cremation 4 Donation 5 Other (Specify) Pritts Funeral Home and Chapel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Acute myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): /Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypertension Diabetes, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation ∟ Accider □ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Box 68760 P.O. Division of Vital Records,

28a-f shov

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er than "natural", or items 23a or the Medical Examiner must be

and Mental Hygiene. is marked other than

permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic to

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attending physician for use as the buria

ed by the detached

signed by

peen

cate has I page 2 s

funeral director,

filled in by the

Medical

with the Maryland

within 72 hours after death

Maryland 21215-0036

Baltimore,

aţ

notified

24 hours after death. Funeral Director. After this certificate completed within 2 To the F Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 W 3rd St Cumberland MD 21502 Paul Snow, M.D.

determined

31. Date filed (Month, Day, Year) NOV 28

4 Homicide

29a. Certifier

(Check

only one

29b. Signature and title of certifier

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Do9157

29d. Date signed (Month, Day, Year)

11/22/11

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Nov $2\overset{\text{Day}}{3}$ IDA WILSON PINKNEY 10:28-M2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 1 F Min Maryland 215 26 5676 81 Director ug Usual Residence of Deceden i Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 500 Lincoln Avenue U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify. If Yes, Give Year or Dates 3 XWidowed 4 Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public School Teacher Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harriett Jones James Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Takoma Park, Md 20912 19a. Informant's Name/Relationship (Type, Print) 500 Lincoln Avenue, Takoma Park, Joy Pinkney, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Lincoln Cemetery 12/2/2011 Brentwood, Md 4 ☐ Donation 5 ☐ Other (Specify) Brothers Funeral dome 22. Name and Address of Facility Hall Frot 621 Florida Avenue, NW, Hall Signature of Funeral Service Licensee Washington DC 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph sician/ ACUTE MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Examiner CORONARY DISEPHSE Se uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) JODRIE D40324 NOVOMBOR 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THROMA PANCK, MARY LAND 7600 CARROLL AVENUE TERRY JODRIE, WAD FACEP

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40176 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CLARENCE NORMAN POSEY 5:40P M DEC. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death CALVERT HOSPICE HOUSE PRINCE FREDERICK CALVERT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. 1 JM 2 JF Hours 2-24-1925 219-12-3447 86 **Director** Yrs. Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director CHARLES MD. INDIAN HEAD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5672 WEST MT. AVENTINE ROAD 20640 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces'
1 X Yes 2 [
If Yes, Give Black, White, etc. þ 1 Never Married 2 XMarried 2 No ARMY Maryland 21215-0036 an "natural", o 1 Yes 2 XNo Specify. Specify: WHITE 3 Widowed 4 Divorced WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. DEPT.OF ARMY Elementary/Seconday (0-12) College (1-4 or 5+) INDUSTRIAL OPERATIONS the U.S.GOVT. 12th Be permit. Page 1 and 2 should be filed.
Department of Health and Mental H.
Important: If item 27 is marked othany injury or other traumatic answer. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ AUBREY CLEVELAND POSEY NORA CATHERINE PATTERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FAITH POSEY-SPOUSE 5672 WEST MT. AVENTINE RD. INDIAN HEAD, MD. 206 Baltimore, 40 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XI Cremation 3 Removal from State METROPOLITAN CREMATORY 4 Donation 5 Other (Specify) 12-9-11 ALEX., VA. M00479 21. Signature of Juneral Service Licensee 22 Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ movan disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** man Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): pue Due to (or as a consequence of) resulting in death) Last burialphysiciar Physician/Medical that the death certificate be Box 68760 the attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown the 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been (Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law has autopsy perform death? this certificate 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 00 Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 💢 Other (Specify) HospiceHa funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 5 Pending 1 Yes Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 238 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/MEND4a,b,c,26penMD12/2/11; EMW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MINNIE RICE 24 437 2011 Medical 4a. Facility Name (If not institution, give street and number)
HCR Manor Care Hy Site Tess or 1 1 allow of Death Pffice Deerges **Examiner** Montgomery Takoma Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🛚 F Months Days Hours Min. 01/19/41 South Carolina 70 Director 579-62-0228 Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County Director 1 X Yes 2 No Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20019 2814 Erie Street NE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Alice Reed Walter Suber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2031 Brooks Drive#723 District Hghts, Md Marion Rice Brown Daughter 20c. Location - City or Town, Sta 2e 0 4 4 7 20b. Place of Disposition (Name of 20a. Method of Disposition Glenwood Cemetery 12/2/2011 1 XBurial 2 Cremation 3 Removal from State Washington, DC 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 2SheadAdFereral Home & Cremation 0777 5732 Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease wronary artery Pnysician/ atheroscleronc disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** failure neart ongestive Sequentially list conditions, Due to (or as a consequence of) rany, leading to inmediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Pregnant at time of death been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Kidney injury 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has director, page 2 s autopsy performed? Yes 2 ☑ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) ၉ this : After thi Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: Af

Completed filled in by the fur Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 72207 11/26/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Advintst Hospital Ansaldo 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 3 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 1:15P. M Physician/ Walter T. Roman November 24, 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🌠 M 2 □ F 93 Days 153-01-1311 Allerth 30, 1918 **Director** Newntgersey Usual Residence of Decedent t0a. State 10b. County the Maryland Town or Location 10d. Inside City Limits Director notified a Maryland Montgomery Silver Spring 28a-f 1 🗆 Yes 2 🗖 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be items 23a oner must be Funeral 3114 Gracefield Road, WC#413 20904 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give 7.7.7 T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian "natural", or i þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates. WII the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Chief Petty Officer U.S. NAVY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Josephine Kosowski ပ္ Frank Roman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Thomas A. Roman -son 98 Hampton Road Hamden, CT 06518 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Remoyal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Columbia Memorial Gardens 12/1/2011 4 Donation 5 Other (Specify) Columbia, Maryland Sign June of Funeral Lervice Licens Donald Avess Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Arteriosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Hypertension Sequentially list conditions, Directo for se a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Completed by Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy
 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Kidney Disease; Advanced Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕇 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 a autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 12+ R15866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, CRNP 3160 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) NOV 29 2011 Registrar

			Pleas	se Type or	Print	in Blac	k Ir	ndelible Ink	k. Ens	ure A	All Copie	s Ar	e Legib	le.		
		For State		State o	f Man	yland / [-	artment of H		and N	/lental Hy	/gien	е			
		Registrar 1. Decedent's Name	Clark Stickelle I	l cotl			Cer	tificate of E	Death			Reg. N	10. 20	11-401	79	
Physicia		Quentir		*	Robi	nson					2. Date of De Month Novembe	Day Year				
Medic Examin		4a. Facility Name (if	not institution, g	ive street and num	ber)		4b. City, Town, or Location of Death					4c. County of Death				
4				Post Lan			Rockville						Montgo	mery		
Funeral Director		5. Social Security No. 233–22–33		. Sex 1 XM 2 □ F		yrs. last birtl	nday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bi (Month, Da Oct. 7	ay, Year))	Birthplace (State or Fore Country) PA	ign	
d iow		Usual Residence of 10a, State	of Decedent 10b. County		110	o City Toyun	wn or Location									
arylan ka-f sh ified a	Funeral Director	MD	Montgo	omery	10	,	Rockville							10d. Inside City Lim 1 ☐ Yes 2 🔀		
the M a or 28 se not	I Dir	10e. Street and Num	nber				10f. Zip Code						10g. Citizen of What Country?			
h with ns 23a nust b	nera	11510 Hi	tching F	Post Lane			20852						United States			
r deat or iten iiner r	y Fu	11. Marital Status 1 ☐ Never Marri	in d O D Maurin	12. Was Dece Armed For	ces?	If Yes specify Cuban Mexican Puerto Rican etc.)						-		American Indian, Vhite, etc.		
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	3 X Widowed		If Yes, Give Year or Da	2 ∐ No e tes.	WW II	1	1 ☐ Yes 2 🛣 No	Specify				Specify:	White		
2 hou "natu	plet	(Spec	15. Decedent's cify only highest	s Education grade completed)		16a.		dent's Usual Occupa kind of work done d		at of worki	ina		Kind of Busin		_	
ithin 7 iene.	Completed	Elementary/Seco	ondary (0-12)	College (1-	-4 or 5+)		life. Do	O NOT use retired) Enginee:						p Research ment Center		
filed wall Hyg	Be	17. Father's Name (F	First, Middle, Las	st)						er's Name	e (First, Middle	dle, Maiden Surname)				
Ment Ment narke	입		Robinso				Sarah Jane Everly							7		
2 shot th and 27 is n traum		19a. Informant's Na Sue Guy					19b. Mailing Address (Street and Number or Rural Route Number, City or 17605 Olney Lane, Rockville, MD									
1 and if Heal item 2		20a. Method of Disp			1	20b. Place of	Dispo	sition (Name of	1		Date	_		y or Town, State		
Page nent o ant: If Iry or			☐ Cremation 3 5 ☐ Other (Spe	Removal from	State	Parkl	y, cren awn	matory or other place Memorial	e)	Decei 201	mber 1,		ockvil			
permit. Departr Import any inji		21. Signature of Fur	neral Service Lice	ensee	2401		22	Name and Address	s of Facili	tv					_	
<u> </u>	H	23a. Part 1. Enter the	be disease or co	MERC.	MO1								877	rk Drive,		
Physician/		shock, or hear Immediate Cause (F	t failure. List onl _! Final	y one cause on ea	ch line.		ot ente	a the mode of dying	y, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Qnset and Death		
Medical		disease or condition resulting in death) Pneumonia Due to (or as a consequence of):												Onset and Death 3 Days		
Examiner	Je.	Sequentially list cor	nditions,			tion								6 Days		
E E	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause) Gastroesophageal reflux disease										20 Years				
executed ian and		that initiated events resulting in death) L				nsequence o		i lellux		case				20 Tears		
ate be ohysici the bu	Physician/Medical			d												
Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the b	/Me	IF FEMALE: 23b. Was decedent	programt	23c. If yes, out	come of p	regnancy			-				20.1 D			
death e atter	sicia	in the past 12 n	nonths?		nant at tim	Fetal death ne of death		Ectopic pregnancy Other (specify)	у				23d. Date of Month	Day Year		
at the o	Phy	9 Unknown Part II. Other signifi	icant conditions			ot roculting is	* * * * * * * * * * * * * * * * * * * *		i- D-4	1	1					
requires that the develeen signed by the sendent beong the second be detached	d by			c Cardio					en in Part	1.				te to the cause of death? Probably 4 Unkno	wn	
v requi	Completed										24a. Was		-	e autopsy findings availal		
The law ate has page 2:	omo										auto		prior	to completion of cause h?		
ician: The certificate rector, pag	Be C	25. Was case referre examiner?	ed to medical					26. Pla	ace of Dea	th (Check		2 (Δ.)	NO I L	Yes 2 No		
Physic this corral dire	으	1 ☐ Yes 2 5 27. Manner of Death	1			2 ER/Out			_ 4 ⊔ Ni		me 5 💢 Resi			pecify)		
nding th. : After e funel	cate	1 XNatural 2 Accident	5 Pending Investigat		h, Day, Ye	28b. T	ime or ijury	28c. Injury work? M 1 🗆			28d. Describe	how inju	iry occurred			
r Attel ter dea rector	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	t be 28e. Place	of Injury -		m, stre	eet, factory, office		-				Rural Route Number,		
oital o			37 1								City or To					
e Hosp 124 hc e Fune detely	Medical	(Check 2	Medical Exa	miner: On the bas	s of exam	ination and/or	invest	occurred at the time tigation, in my opinion death occurred at the	n, death or	courred at	the time date:	and place	e and due to t	the cause(s) and manner s	tated	
To the Hospital or Attending Pr within 24 hours after death. • To the Funeral Director: After th • completely filled in by the funeral	2	29b. Signature and t		1/7	7		yc,	29c. License	number		os, and due to			onth, Day, Year)		
4+1		1	byn	1/1/1	eys.	1/			1840			No	ovember	28,2011		
		30. Name and addre	-					•	#?	1/4 1	Rocksti 1	16	MD 209	850		
Stat	e.	31. Date filed (Month	n, Day, Year)	32 Re		Signature		Let Dilve	, II Z	_ T , I	WCKV11	109	111 ZU			
Registra	ar	NI	N 2 9 20	HI 1/2 N		1. 1	S EX	100								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 25, 2011 November 1950 Sarit Raviv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Rockville Montgomery 7. Age (In vrs. last birthday If Under 24 Hrs. Birthplace (State or Foreign Country) Year 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) 218-53-5593 Director 1 □ M 2 🗓 F Yrs. 52 12/27/1958 Israel Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🗶 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be injury or other traumatic Funeral 264 New Mark Esplanade 20850 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **5+** d Mental Hygiene. marked other tha Information Security Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Amnon Itkin Edna Gruber t and 2 should by Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yossef Raviv - Spouse 264 New Mark Esplanade, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I-Important: If ite any injury or otl Date Page 1 cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 11/27/2011 | Clarksburg, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses (de 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the shock, or heart failur or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician. Metastatic Vulvar Cancer Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last litransit Sansit and Due to (or as a consequence of): use as the burial attending physician Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year Pregnant at time of death signed by the aid be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy performed? Yes 2 X N 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 DOA pletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Bindu C. Joseph, M.D.,

NOV 29 2011

31. Date filed (Month, Day, Year)

D0060634

1160 Varnum Street, #021, Washington, DC 20017

November 26, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Daisy Pearl Reifsnider 5:35 p November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing & Rehabilitation Ctr Taneytown Carroll If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Sep 1, 1914 Months Hours 1 M 2 X F 215-42-1994 97 Maryland Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director Carroll Keymar 28a-f Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral 21757 USA 1625 Keysville Bruceville Road 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: white 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home should be filed with and Mental Hygien ris marked other th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daisy Grimm John Maurice Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 1625 Keysville Bruceville Road, Keymar, MD 21757 David M. Reifsnider, son permit. Page 1 and.
Department of Healt
Important: If item 2:
any injury or other h 20b. Place of Disposition (Name of cemetery, crematory or other place)
Grace UCC Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 11/29/2011 Taneytown, MD Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Vascula bral disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner V Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consecuence of Examin Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as attending F FEMALE: Ise (23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Month Pregnant at time of death 5 Other (specify) the a g Unknown 9 Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b 2 No 3 Probably 4 Lunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed' death? certificate I 1 🔲 Yes 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🗷 Natural 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatore and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 20440 RO69 11 25 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print TACOULLINE HEARN 688-C POOLE R RUZD WESTMIN STER MARYLAND 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	tate of Maryland				Mental Hy	giene	0.0.1			
			Registrar 1. Decedent's Name (First, Middle, Last)		Cen	tificate of E	<i>Death</i>	2. Date of De	1 4018				
Pl	nysicia Medic	_		ichards				Month	Day 29	2011	3. Time of Death 8:15 A M		
E	xamin		4a. Facility Name (if not institution, give street	and number)	4b. City, Town, or	Location of Death		4c. Cd	4c. County of Death				
Same -			Southern Maryland H			Clinto					eorge's		
	ineral rector		5. Social Security Number 6. Sex 1 🔀 M	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Yea <i>r)</i> 1951	Co	Birthplace (State or Foreign Country)		
			Usual Residence of Decedent		Yrs.			4 21	1951	Pri	nce George's		
yland	-f sho ed at	ctor	10a. State 10b. County MD Prince Geo1	·	, Town or Loc	ation					10d. Inside City Limits		
e Mai	r 28a notifi	Dire	10e. Street and Number	Bra	ndywin	10f. Zip Code			10a China	of Mhat C	1 🗆 Yes 2 No		
with th	23a o st be	Funeral Director	15103 Croom Road			20613			USA	n of What C	ountry?		
eath	tems er mu	Fune	11. Marital Status 12. V	Vas Decedent Ever in U.S.		las Decedent of Hi			14.		erican Indian,		
36 after o	l", or camin	þ	1 Never Married 2 Married	Armed Forces? Yes 2 X No Yes, Give		Yes, specify Cubar ☐ Yes 2 ☑ No		nican, etc.)	So	Black, Whi ec <i>ify:</i> Wh			
-00	atura cal Ex	Completed	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educati	ear or Dates.		ent's Usual Occupa				of Business			
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21 d within	her th		9	ellege (1 4 el e 1)	Heavy	Equipmen	t Operat	or Farm	Fari	n			
and be filed ntal H	ed of	To Be	17. Father's Name (First, Middle, Last)	harda			18. Mother's Nam			_{name)} Lchard	le		
ould to	mark		Frank Sylvester Ric 19a. Informant's Name/Relationship (Type, P		10h Mailine	g Address (Street a				_			
M2 sh	27 is er trau	- 1	Frank Richards, Jr.		I .	l Croom R				20613			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.	fiter rothe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remailer		ace of Dispos	sition (Name of atory or other place		Date		tion - City o	r Town, State		
timent	tant: If jury or		4 Donation 5 Other (Specify)	JVai iloili Glalc	Peter'	s Cemete	ry 12/3			dorf,			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	lmpor any in		21. Signature of Funeral Service Licensee	M00817	22. 30	Name and Addres 1195 Thre	^{s of Facility} Bri e Notch	nsfield Road Ch	-Echol arlot	ls Fur ce Hal	neral Home, 11, MD 20622		
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cat	ons that caused the death use on each line.	W.				rest,		Approximate Interval Between		
PlyW Me	idian. edical		Immediate Cause (Final disease or condition, resulting in death) A metastatic Squampy Cell Carcinoma Onset and D Due to (or as a consequence of):										
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100	+	iner	Sequentially list conditions, h any, leading to immediate cause. Enter Underlying	Due to (or as a conseque									
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pe exe	burial	calE	resulting in death) Last Due to (or as a consequence of):										
760 licate	g pnys	ledical	d										
certif	r use a	an/N	ZSD. Was decedent pregnant	yes, outcome of pregnan		Ectonic pregnance	.,		230	d. Date of de	elivery		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	ne att	Physician/M	1 Ves 2 No	Pregnant at time of de Unknown		Other (specify)				Month	nth Day Year		
or the	detacl		Part II Other significant conditions contribu	uting to death but not resu	llting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute t	o the cause of death?		
S, F	n sign	ed by	Bilateral Meumo	ma with	Copini	aton Far	live	1 🗆	1 Yes 2 No 3 Probably 4				
V requ	2 shou	Completed	Hyper calcernia		,	5		24a. Was			utopsy findings available completion of cause of		
Rec The la	ate na page	E	J'					auto perfo	ormed No	death?			
tal	ector,	Be	25. Was case referred to medical examiner?	ral·		Loui	ice of Death (Chec						
Phys	eral dir	<u>ا</u> ي	T Tes 2 M2 No	1 Inpatient 2 I	ER/Outpatient 28b. Time of	3 DOA Othe	4 ☐ Nursing Ho	ome 5 Resi			cify)		
on C	r: Arre	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work'		Zod. Describe i	iow injury or	,curred			
/iSic	recto byt∯	ertif	3 Suicide 6 Could not be 4 Homicide determined	28f. Location (S		umber or Ri	ural Route Number,						
Dital o	filled in			building, etc. (Specify)									
e Hos	erun	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: Control only one) 1 Certifying Nurse Pra	n the basis of examination	and/or investig	gation, in my opinio	n, death occurred a	t the time, date a	and place, ar	d due to the	cause(s) and manner state		
To the within	d moo		29b. Signature and line of certifier	outdoiler. To the pest of the	y Knowledge,	29c. License		ace, and due to			th, Day, Year)		
			> Klather mg			D003	55120		NUV	ember	- 29,2011		
10 R	me		30 Name and address of person who complete the chard Palmar MD	1325 Southe	mav.	unne SE Su	ite 310 L	Jashins					
	Stat egistra	e	31. Date filed (Month, Day, Year) DEC 0 2 2011	32 Registrar's Signatu	. Sa	Ne.		V					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | State
Registra Amend#2.4c. PerPhys. POC12-6-11cr Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27, Day 2011 Physician/ NOV. 4:35 P M ROBINSON **BOBBY** LEE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BLATIMORE BALTIMORE TOWSON GILCHRIST CENTER FOR HOSPICE CARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Davs Hours Min 80 Director 418-34-2582 1 XM 2 □ F JAN. 23, 1931|ALABAMA Usual Residence of Decede r 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No INDIAN HEAD MD CHARLES 10f. Zip Code 0 10e. Street and Numbe 10g, Citizen of What Country? ms 23a or must be r Funeral U.S.A. 20640 5350 NELSON POINT ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Examiner Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 TrNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK 'natural", 3 🌠 Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Il Hygiene. other than " 5 + YRS. Elementary/Secondary (0-12) DEPT. OF SOCIAL SERVICE the MINISTER/SOCIAL WORKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I 2 FILES MATTIE ROBINSON BARNEY other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other tratonce. 17 MILLSTONE ROAD RANDALLSTOWN, MD 21133 SHERRIE R. BAILEY-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, LANDOVER, MD HARMONY MEMO. PARK 12-2-2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. Signature of Funeral Service Licensee 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the divath. Do not inter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Prosta disease or condition tastalic Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir and Due to (or as a consequence of): physiciar Physician/Medical P.O. Box 68760 the ding IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Hiknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? has After this certificate 1 Yes 2 No **Division of Vital** Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 146 ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely within 2 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) MD 071040 27 11 8 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) ARATHI KUMAR 6701 NORTH CHARLES SUITE 4105 BAJIMORE 31. Date filed (Month, Day, 32. Registrar's Signatur State

DHMH 17 Rev 06-2011

Registrar

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NUA 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 1-10AM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Bowie 1808 Price Lane Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. rge (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Hours 80 577-40-7136 1 🗆 M 2 🔽 **Director** Yrs New York Dec. 20, 1930 or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State with the Maryland Director 1 ☐ Yes 2 🔀 No Bowie Prince George's MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Numbe ō er than "natural", or items 23a or the Medical Examiner must be Funeral U.S.A. 20716 1808 Price Lane death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc Armed Forces ð 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 XNo Specify White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Floral Industry Gardener Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Jeanne Lapallo John Mangels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1808 Price Lane, Bowie, MD 20716 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Donald E. Stelfox - Husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date Lakemonta Mendrial ■XBurial 2 ☐ Cremation 3 ☐ Removal from State Davidsonville, MD 5 Other (Specify) 11-29-2011 Gardens Donation of Finer of Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 H Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final UN ONT Prij i ian disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last trar Due to (or as a consequence of) nding physician use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be twithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the financial completely filled in by the financial director. IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent preg 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie U

State Registrar 30. Name and address of person

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		1	For State of Mary State Registrar		rtment of He tificate of De			ene 20	11 40185			
f	Physicia	n/	Decedent's Name (First, Middle, Last) Barbara Ann Smith	3. Time of Death								
	Medic	al .	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death	Month 11/27/2	/2011 1454 M 4c. County of Death				
	Examin	er	AAMC		Annap				Arundel			
	Funeral			yrs. last birthday) 57		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear)	Birthplace (State or Foreign Country)			
1	Director		213-64-4212 Usual Residence of Decedent	Yrs.			1/19/19	54	MD			
	and show	힏	10a. State 10b. County 10c	c. City, Town or Loc					10d. Inside City Limits			
	Maryl 28a-f otifie	irec	MD Anne Arundel		West R	River —————			1 ☐ Yes 🏖 No			
	th the 3a or t be n	Funeral Director	10e. Street and Number		10f. Zip Code	778	10g	g. Citizen of V	What Country? USA			
	ath wi	nne	4507 Owens Valley Dr. 11. Marital Status 12. Was Decedent Ever	in U.S. 13. W	/as Decedent of Hisp Yes, specify Cuban,		cify Yes or No-	14. Rac	e - American Indian,			
တ္တ	fter de , or its amine	þ	1 Never Married 2 XX Arried Armed Forces? 1 Yes XX No		Yes, specify Cuban,		Rican, etc.)	Specify:	ck, White, etc. White			
21215-0036	ours at	Completed	3 Widowed 4 Divorced Year or Dates.		ent's Usual Occupati		16		usiness/Industry			
75	n 72 ha an "na Medic	npldm	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k	ind of work done dui NOT use retired)	ring most of workir	ng					
212	withir giene ner th		12	Sei	lf Employe				Le Search			
and	e filed tal Hy ed otf	To Be	17. Father's Name (First, Middle, Last)		1		(First, Middle, Mai htherbury					
Ĕ	ould b nd Mer mark matic		Robert Beneze, Sr. 19a. Informant's Name/Relationship (Type, Print)	19b Mailin	g Address (Street an				State, Zip Code)			
Ma	d 2 sh alth ar 1 27 is er trau		Bruce Smith Spouse	111	7 Owens Va				MD 20778			
Baltimore, Maryland	of He of He item		20a. Method of Disposition 1 Burial	Ob. Place of Dispos cemetery, crem	sition (Name of natory or other place)	С	ate 20	c. Location -	- City or Town, State			
ţį	t. Page tment tant:		4 ☐ Donation 5 ☐ Other (Specify)		Crematory			_	cnie, MD			
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Pervice Licensee		Name and Address Ridgely		desty Funapolis,	meral MD 21	Home, P.A. 1401			
П			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	1	Approximate Interval Between Onset and Death							
	Medical	Immediate Cause (Final disease or condition resulting in death) a. Metastate Cause Ca										
	Examiner		resulting in death) Due to (or as a consequence of): Multiple (CONTROL OF)									
		iner	be sequentially ils conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):									
	cuted .nd transit	Examiner	Cause (Disease or injury that initiated events C.									
	sate be executed physician and s the burial-transit	SalE	resulting in death) Last Due to (or as a consequence of):									
2092	icate t g phys	fedical	d						-			
Box 687	ending r use	an/N	IF FEMALE: 23c. If yes, outcome of p	regnancy Fetal death 3	Ectopic pregnancy				ate of delivery			
Bo	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			IVIC	onth Day Year					
P.O.	hat the ed by detac	by Ph	Part II. Other significant conditions contributing to death but n	ibute to the cause of death?								
	uires t n sign uld be						1 🗆 Yes	2 No	3 Probably 4 Unknown			
Sor	aw req as bee 2 sho	Completed					24a. Was an autopsy		Were autopsy findings available prior to completion of cause of			
Be	rsician: The law r s certificate has t director, page 2 s						performe 1 Ves 2		death? 1 Yes 2 No			
ital	sician certifi irector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien	Other	ce of Death (Check	only one) me 5 ☐ Residen	6 \(\tau \) Oth	ner (Chasife)			
of V	g Phys er this neral di	e: To	27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury : work?	at	28d. Describe how					
O	endin eath. or: Aft	fical	2 Accident Investigation		M 1 🗆 Y	∕es 2 ☐ No		<u> </u>				
Division of Vital Records,	I or Attending after death. Director: After din by the funer	Certificate:	4 Homicide determined 28e. Place of Injury - building, etc. (S		eet, factory, office		28f. Location (Stre City or Town,		per or Rural Route Number,			
Ω	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death o	occurred at the time,	date and place, a	nd due to the caus	e(s) and man	ner as stated.			
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check 2 Medical Examiner: On the basis of exam only one) 3 Certifying Nurse Practitioner: To the be	ination and/or invest st of my knowledge	death occurred at the	e time, date and pla	ce, and due to the	cause(s) and	manner as stated.			
			29b. Signature and title of certifier	200 A	29c. License	number	29	d. Date signe	ed (Month, Day, Year)			
U	ell's		30. Name and adddess of person who completed cause of death	(Itam 23a) (Turk E	Print)	5306		(//	h ((()			
	. 3		Curtes Harris, M.D. 2003 W	Willa /	akwag	Suits	210 a	nnag	whis, 640 21401			
	Sta		31. Date filed (Month, Day, Year) 32. Pegistrar's	Signature								
	Registr	ar	NOV 2 9 2011	A. 1	all							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) November 26, Lamon Arlie Stewart, Jr. Physician/ 2011 7:45 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 3, 1940 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213-38-1023 **71** Months Hours Georgia Director 1 🔀 M 2 🗆 F ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Director Annapolis Maryland Anne Arundel Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21403 24 Chesapeake Landing 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, 11. Marital Status rmed Forces?

Yes 2 \(\sum \) No ed other than "natural", or i event, the Medical Examin þ 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify. If Yes, Give Year or Dates. 1967–70 Specify. 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) Orthodontics Orthodontist Be 18. Mother's Name (First, Middle, Maiden Surname) . Father's Name (First, Middle, Last) Lamon Arlie Stewart ൧ Rhoda Vandiver traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 24 Chesapeake Landing Annapolis, Maryland 19a. Informant's Name/Relationship (Type, Print)

Judith Stewart/wife Department of Health are I mportant: If item 27 is any injury or other traumone. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 12/1/2011 Baltimore, Maryland Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 100 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prevnonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner hour Sh カナ・と Sequentially list conditions, as a consequence of) if any, leading to immediate Cause (Disease or Injury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) been signed by the a should be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas page 2 autopsy death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I completely filled in by the funeral director, pag Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) 2 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0

State Registrar he, T

31. Date filed (Month

2511

strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 7:40 P_M November 29, 2011 Physician/ Allen Scurlock James Medical 4c. County of Death
Prince George's 4b. City, Town, or Location of Death Clinton 4a. Facility Name (if not institution, give street and number) **Examiner** Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 579-20-9652 **Director** 1 X M 2 □ F 88 Dec 16, 1922 North Carolina Usual Residence of Deceden 10d. Inside City Limits 28a-f show 10c. City, Town or Location must be notified at Director 1 X Yes 2 No Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 23a U.S. 20020 Funeral 2232 34th Street, S.E. Page 1 and 2 should be filed within 72 hours after death "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 X Yes 2 □ No African American . 0. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. 3 X Widowed 4 Divorced Completed Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) U.S. Government College (1-4 or 5+) Records Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Johnnie Scurlock Lovie Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 345, Newburg, MD 20664 Michael A. Scurlock-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If ite any injury or ot 1X Burial 2 Cremation 3 Removal from State Suitland, MD 12-5-2011 Washington Nat'l 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 2504 28th St., N.E., WDC 20018 Signature Juneral Service Licenses eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Preysician/ HYDOXIA disease or condition resulting in death) Medical Due to (or as consequence of) **Examiner** RATOR Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury HYPOTENSION To the Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL PAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an MALNUTRITION page 2 autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes 2 No s after de. • al Director: A Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 124 hours after e Funeral Dire letely filled in b Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2.

To the F
complet 3 only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 11130/2011 D0064961 DR WASERWA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURRATIC RUAD CUMMU), MD 20735 32. Registrar's Signature DEC 0 2 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11/25/2011 Constance Zelda Sickle 10:03 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 8011 Grand Teton Drive Potomac If Under 1 Year 9. Birthplace (State or Foreign Country)
Washington, DC **Funeral** 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🛭 F Days 577-01-7002 0976971918 **Director** 93 Usual Residence of Decedent or 28a-f show notified at 10a. State the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Potomac 1X Yes 2 ☐ No MD Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral with ıral", or items 23a Examiner must b USA 20854 8011 Grand Teton Drive . Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", White Completed 3 XWidowed 4 Divorced Year or Dates Me fical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Retail Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Rosenburg Sue Sheer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Galkin - Daughter 8011 Grand Teton Drive Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
King Dayid
Memerial Gardens 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/27/2011 Falls Church, VA . Signature of Funeral Service Licenses 22. Name and Address of FacilityEdward Sagel Funeral Direction, Inc Victoria MO1641 1091 Rockville Pike Rockville MD 20852 Deaman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Ischemic Cardiomyapathy 10 years Medical Examiner Chronic Coronary Artery Disease 15 years Sequentially list conditions, Due to (or as a consequence of). e attending physician and cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year 1 Yes 2x Yes 21 No detached the 9 Unknown P.O. signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Chronic Renal Failure Completed 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo certificate 1 🗌 Yes 2 🗌 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work Accident Suicide M 1 ☐ Yes 2 ☐ No Director; Investigation within 24 hours after de To the Funeral Directo 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and due to the cause(c) and manner stated. imid at the time, data and plane, and due to the cauca(c) and manner as states 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year) 11/25/2011 DO7147 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Allen Nimetz
31. Date filed (Month, Day, Year)

Chevy Chase, MD 20815

5530 Wisconsin Avenue Suite 700

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Evelyn SAILE 2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Gilchrist Hospice Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 180-24-6687 1 🗆 M 2 💢 F Pennsylvania **Director** 1929 82 May 11, Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director with the Maryland Gaithersburg 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 0 must be 20879 Funeral 23a 18932 Linden House Road items permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ٥, by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Jewish Community income in and Mental Hygiene.
It is marked other than "r (Give kind of work done during most of working life DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Center Program Director Be 18. Mother's Name (First, Middle, Maiden Surname)
Lottie Krickstein 17. Father's Name (First, Middle, Last) Nathan Rothschild ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau 993-M Heather Ridge Dr., Frederick, MD Louisa Bowker, Daughter 20a. Method of Disposition

1 Deurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11/30/11 cemetery, crematory or other place) Garden of Remembrance Memorial Park Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Financial Service Licensee Torchinsky Hebrew Funeral Home 23a. Part 1-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Immediate Cause (Final 20012 Approximate Interval Between Onset and Death Immediate Cause (Final KIONEY DISEASE Physician/ ONIC disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burialnding physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Por Month Day 5 Other (specify) Pregnant at time of death ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by NEMENTIA 1 Yes 2 No 3 Probably 4 Unknown ADRITIC STENOSIS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy perform CORONARY ARTERY DISEASE Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident ithin 24 hours after death

the Funeral Director; /

ompletely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29d. Date signed (Month, Day, Year)

NOVEMBER 29. 2011 29b. Signature and title of certifi 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MO 21044 DANIEUE DOBERMAN, MD 6336 CEDAR LANE

DHMH 17 Rev 06-2011

State

Registrar

Date filed (Month, Day, Year)

NOV & 0 2011

82. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 29c per DVR G922 12/20/11 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra AMEND#7+8perINF, 12/2/11; BMW, McCo Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov. 23, ^D2^V011 Physician/ 7:00 Charles p M Xavier Suraci, Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 9817 La Duke Drive Kensington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Feb. 10, 1933 78 578-42-5193 1 🖾 M 2 🗆 F **Director** D. С. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland notified at 10a. State rector 1 Yes 2 X No MD Kensington Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 ems 23a or Funeral USA 20895 9817 La Duke Drive items 2 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc Armed Forces Korean ö þ 1 Never Married 2 Married 1 X Yes Maryland 21215-0036 within 72 hours after Specify.White If Yes, Give Korean Year or Dates. Conflict 1 Yes 2 No Specify Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Air Force Assoc. President Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 0 June C. Hunter Charles Xavier Suraci, Sr. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 10704 St. Paul Street, Kensington, MD 20895 Samera Rahman/Personal Rep Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Dec. 5, 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licens Francis J. Collins Funeral Home Inc 500 University Blvd. W. Silver Spring, MD 20901 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between 2nset and Reath Immediate Cause (Final Pneumonia Ph_sician/ disease or condition **Medical** resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami B Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial train Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2√ No 3 Probably 4 Unknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 1 ☐ Yes 2 ☐ No After this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည XX No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one 29b. Signature and title 29d. Date signed (Month, Day, Year, Nov. 28, 2011 0+1 D01601 dadress of person who completed cause of death (Item 23a) (Type, Print)
Blackburn, MD 5454 Wisconsin Ave, Chevy Chase, MD 20815 nt. Registrar's Signature barked NOV 2 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Malcolm William Smith 2011 9:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16 Rabbit Run Lane Ocean Pines Worcester . Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 90 14072371921 Country) Director 181-12-0595 Vrs PA Usual Residence of Decedent 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester 1 Yes 2 X No Ocean Pines 10e. Street and Number 10q. Citizen of What Country? Funeral items 23a 16 Rabbit Run Lane 21811 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married X Yes Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced If Yes, Give Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ltal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) fitter steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of 2 Howard J. Smith Elizabeth Smith 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is in any injury or any 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Smith / son 16 Rabbit Run Lane, Ocean Pines, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Irvine Funeral Hm 11/29/2011 Scwickley, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1 Inter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest short, or held failure. List only one cause on each line. Approximate Interval Between Onset and Death sh and, or heart faillu Immediate Cause (Final Physician/ End stage renal failure disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-1 Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Day Pregnant at time of death Month Year 1 Yes 20 9 Unknown 2 No signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Aortic_aneurysm 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Yes 2 🔀 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death nours after death. neral Director: After the filled in by the funeral. 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Hospital 1 Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | Oct | Mining Nurse Practioner: To the best of my knowledge, death or number of the time, date and place and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of dertifie 29d. Date signed (Month, Day, Year) 0056241

State

Registrar
DHMH 17 Rev 7/2009

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Romaine M. Rhoten Seipp 2011 7:25 a М November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster 1258 Old Manchester Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Pay, Months Days Min 1 M 2 F Hours 219-14-9493 86 Yrs Mary Tand Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must have a second 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Westminster 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 1258 Old Manchester Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced white Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Assembly Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ဂ Edgar Eugene Rhoten Thelma Beatrice Davidson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Sacred Heart Lane, Reisterstown, MD 21136 Sharon L. Hamilton, daughter 20b. Place of Disposition Warm of 20a. Method of Disposition 20c. Location - City or Town, State 11/30ື/ື່2011 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley United Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as car, ac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentistly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy
☐ Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant Pregnant at time of death 1 Yes 2 No detached To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death?

1 Yes 2 No this certificate Yes 2 XNo the Hospital or Attending Physician: The Hours after death.
the Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ဂ္ 1 L Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NOV 2 8 2011 Registrar's Signature State

Registrar

Park

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November ^{Day}0, Physician/ Sarah Catherine Stultz 8:45 p 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Westminster 4c. County of Death Examiner Carroll Carroll Hospital Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Sep 26. 215-26-1182 Days Hours Min 1 - M 2 X F Months 99 Mary land **Director** 1912 Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Taneytown Maryland Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 1800 Crouse Mill Road 21787 USA items 2 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Completed th and Mental Hygiene.
27 is marked other than "natural traumatic event, the Medical F. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Factory Worker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Glacken Amos Hofe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1799 Crouse Mill Road, Taneytown, MD 21787 Doris E. Staley, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other placel 5 11/25/2011 Taneytown, MD Mt. Pleasant UM Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers—Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 R. I 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner pertendia Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) VINEIR burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical law requires that the death certificate be Box 68760 ed by the attending phys detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ils certificate has been signed I director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) _2 No 28a. Date of injury (Month, Day, Year) 2 ER/Outpatient 3 DOA 28b. Time of injury injury ပု To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this or completed filled in by the funeral dir this 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 21, 2011 AUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Cent

Registrar DHMH 17 Rev 7/2009

State

HINTU SHARMA

NOV 2

31. Date filed (Month, Day, Year)

MD

Registrar's Signature

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WESTMINSTER, MD. 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ e e :12 AM ZOI Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** es g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Pennsylvania Days (Month, Day,) Months Hours Min. 1 🗷 M 2 🗆 F Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location by Funeral Director 1 ☐ Yes 2 V No non 0 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Forces:

1 Yes 2 No
1 Yes, Give
1945

Year or Dates. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White 3 🗌 Widowed 4 🗌 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manutacturina VISOF Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) foren 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 A-Cremation 3 Removal from State le Cremotos NOV. 25 2011 ansda 4 ☐ Donation 5 ☐ Other (Specify) AVE . Signature of Ameral Service Licensee 22. Name and Address of Facility tine akler Fill Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line, nset and Death Immediate Cause (Final Physician nocar month disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Divisité (or es e punsaquence offi signed by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ☐ Yes _ _ ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 🗭 Residence 6 Nother (Specify) Hospital: 2 **N**No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b, Signature and title of certifie 34208 UWald 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LindaWalsh,M.D. Jarretteville M 718 Norrisville 31. Date filed (Month, Day, Year, Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 30, 2011 Physician/ 7:18 a M Jean Scarano Karen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Lexington Park 22030 Oxford Court #11A 8. Date of Birth (Month, Day, Year) 05/04/1944 Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F 67 214-42-4697 Washington, DC Director Usual Residence of Decedent or 28a-f show notified at show 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 K No Lexington Park St. Mary's Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ò r items 23a or iner must be r Funeral USA 20653 22030 Oxford Court, Apt. 11 A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iter edical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Accounting 12 Accountant Be permit. Page 1 and 2 should be filed verbartment of Health and Mental Hyg Important: If item 27 is marked othnany injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Shirley Benedict Eugene Gillroy Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20619 23250 Chestnut Oak Trail, Unit 1025 California,MD Dorianne Brown/ Sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery crematory or other place)
Mattingley-Gardiner
Funeral Home Crematory 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/01/2011 Leonardtown, MD 21. Signature of Funeran Service Lice 2. Name and Address of Facility
Mattingley—Gardiner Funeral Home, P
41590 Fenwick Street, Leonardtown, 20650 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final apstragre Dumonary Physician/ CLOVIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examine quentially list conditions. cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year ρ Month Day 1 Yes 2 Mo Pregnant at time of death the a 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 191502592101 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? OBESUY 24a. Was an page 2 performed certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director: After thi

mpleted filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗎 No М Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 To the I within 2 To the F complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HTATTUM

DHMH 17 Rev 7/2009

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32. Registrar's Signature

50058290

STIL SARVIS ANGHUE SUME 200, RIVERBALE UD 20737

29d. Date signed (Month. Day, Year)

36

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Patricia Louise Schwier Medical 11/29/2011 6:45 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6725 Maxwell Drive Hughesville Charles **Funeral** Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 12 3 1 9. Birthplace (State or Foreign 1 🗆 M 2 🛣 F 230-64-6475 Director Hours Min Pennsylvania Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-i sho 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f s MD Charles Hughesville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6725 Maxwell Drive 20637 ural", or items a USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 😿 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black, White, etc. 3 - Widowed 4 - Divorced 1 ☐ Yes 2 🔀 No Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) 5+ Charles County Science Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clyde Branscome Opa1 Bo1t McPeak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Schwier / Husband 6725 Maxwell Drive Hughesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Prince Frederick, MD St. Paul Episcopal Cem 12/6/2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols Funeral Home, M00817 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Breast disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Examine Due to (or as a consequence of death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ę in the past 12 months? 3 Ectopic pregnancy signed by the al d be detached fo 1 Yes 2 9 Unknown Pregnant at time of death 5 Other (specify) 2 XNo Day Year Unknown or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 X No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA funeral 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Alatural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 2 Accider
3 Suicide 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 0005906 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15) pme

DHMH 17 Rev 7/2009

Registrar

Suite 105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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3. Time of Death

10d. Inside City Limits

Approximate Interval Between

Years

Year

Day

29d, Date signed (Month, Day, Year)

December 12, 2011

1 Yes 2X No

6:00

WV

State Registrar 29b. Signature and title of certifier

30. Name and address of person who comp

31. Date-filed (Month, Day, Year, 32. Registrar's Signature 5 2011

Chitra Desikan Rajagopal MD, 18111 Prince Phillip Dr., #329, Olney, MD 20832

use of death (Item 23a) (Type, Print)

29c. License number

D42452

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2:20 PM 201 December Michael Jason St. Clair Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown Meritus Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Hours 08/21/1974 1 X M 2 □ F Months 37 Director 217-04-4067 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10c. City, Town or Location of Health and Mental Hygiene. it item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Hancock MD Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21750 14466 Hollow Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 X Married ☐ Yes 2 🗓 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify If Yes, Give White Completed 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Delivery Service 8 Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic eve ည Lafaune McCormick Edgar Lee St. Clair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14466 Hollow Road Hancock, MD 21750 Barbara Diane St.Clair/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Orchard Ridge Cemetery11/09/2011 Hancock, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 MUU699 Approximate Interval Between Onset and Death 23a. Ourt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line ENCEPHALOPATHY Immediate Cause (Final HEPATIC Ph. sician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day be detached for 5 Other (specify) Pregnant at time of death 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has autopsy performed' 1 🗌 Yes 2 🗆 No certificate 25. Was case referred ty medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: npatient 2 ER/Outpatient 3 DOA ဂ္ 1 🗌 Yes After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Watural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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HUSCISTOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 40199 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 6, 2011 Gerald Humphrey Smith Physician/ 10:03 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick 414 Schley Avenue Social Security Number 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 220-28-3592 X M 2 D F Director 88 May 30, 1923 Brazil 28a-f shov 10d. Inside City Limits 10c. City. Town or Location must be notified at Director 1 X Yes 2 □ No Frederick Maryland Frederick 10f. Zip Code 21702 10g. Citizen of What Country? 10e. Street and Number 5 U.S.A. Funeral 23a 414 Schley Avenue ural", or items? death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 🟋 ☐ No Specify White "natural", Completed 3 X Widowed 4 Divorced Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Banking Vice-President Be 17. Father's Name (First, Middle, Last)
Frederick William Smith 18. Mother's Name (First, Middle, Maiden Sumame) Rhoda Gardner ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7632 Kincheloe Road, Clifton, VA 21024 7632 Kincheloe Road, Clifton, VA Mrs. Jody A. Ward, daughter 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery Dec. 10, 2011 Department of H Important: If ite any injury or ot Frederick, MD 4 Donation 5 Dother (Specify, 21. Signature of Fund of Lervice Lice Keeney and Bastord PA_Funeral Home M00255 106 East Church St., Frederick, MD 21701 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause nset and Death Immediate Cause (Final Ph, sician/ star. Meta disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a. Was an autopsy has 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 2 501 W 7th Street Frederick, MD 2170

State Registrar and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per FH G923 1/05/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Richard A. Sliger, II December 4:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Frederick <u>Frederick</u> 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Unde 7. Age (In yrs. last birthday) **Funeral** Hours Min 212-38-8521 **Director** 1 😿 M 2 🗆 F 10/23/1940 Maryland 71 Usual Residence of Decede 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified Y☐ Yes 2 ☐ No MD Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? Funeral United States 30 North Place 21701 death v 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No If Yes, Give Year or Dates. 1966 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced "natural", or by Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. Specify: White Completed 61967 Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Home builder Construction Be Department of Health and Mental H Important: If flem 27 is marked oth any injury or other traumatic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Richard A. Sliger Blanche Crum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jessica Clinesmith/stepdaughter</u> 2049 Sumner Dr., Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery | 12/12/2011 | Frederick, MD Signat re o Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home regullifle MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause og each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ing Cancer disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause Enter Industry To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 🗌 No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 29b. Signa Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah Frederick MD 21702 65 temen 1 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ DECEMBER 2011 a^{M} 1:05 LISA N. SPRAY Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Kent Chestertown Chester River Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** sept 14 Delaware 1 □ M 2 🔀 F ^{rear)}964 219-80-0813 47 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at within 72 hours after death with the Maryland Director a or 28a-f shoe of short 1 X Yes 2 No Galena MD Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number be Funeral "natural", or items 23a U.S.A. 21635 135 North Main St. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Armed Force by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetologist Beauty Salon 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Winifred DeMond Donald S. Newnam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Galena, MD. 21635 (son) 135 N. Main St. Anthony Spray 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Cremation 3 ☐ Removal from State 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Dopation 5 ☐ Other (Specify) 12/14/11 Galena, MD. Galena Cemetery any injury ^{22. Name and Address of Facility}
Galena Funeral Home of Stephen L.
118 West Cross St. Galena, MD. 21 21. Signature MOO510 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Enter the Interval Between ck, or heart Onset and Death Immediate Cause Final END STAG & Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CIRRHOSIS Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of). resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown P.O. signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 s autopsy performed 1 🗌 Yes 2 🗌 No Yes 2 X No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Yes 2 🗌 No 1 Inpatient 2 K ER/Outpatient 3 IDOA မ within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 Yes 2 No 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific December 6, 2011 D0070976 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jorge Uribe, 215 North St M.D. Elkton, MD, 21921 Suite A

State Registrar 31. Date filed (Month, Day,

32. Registra/s Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William H. Taylor November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BWMC Anne Arundel Glen Burnie Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday) 1 **XX**M 2 □ F Hours Min. 219-32-1633 2 1 2 1 1 9 3 5 Director 76 Usual Residence of Decedent show 10a. State with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes XX No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1211 Hanson Way 21144 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 XXves 2 \sum No 1957- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates. 1 Yes 2XXNo Specify: White Completed 3 Widowed 4 Divorced Specify: 1960 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) XEROX Technician Be filed \ Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Taylor, Sr. Helen Work 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Olson Severn, MD 21144 Daughter 1340 Ava Rd. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 4 ☐ Donation 5 ☐ Other (Specify) 11/28/2011 Crownsville, MD 21. Signature of Funer Vivice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) dau Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Dause (Disease or imjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year s been signed by the sahould be detached if Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypernatremia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Acute Kidney Failure performed? After this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 HNo Other: မှ 1 Tripatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work' 1 Yes 2 No after death Director: / Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D006823 November 21 2011 ani ca iova cr'c Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVE, GLEN Burnce MD 21061 301 HOSPITAL 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

NOV 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ G. Thai November 24, 2011 11:52 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 217-33-7417 1 **X** M 2 □ F 80 China March 9, 1931 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 28a-f s MD 1 Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral 293 North Van Buren Street 20850 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. is marked other than "natural", or 1 Never Married 2 Married Completed by Maryland 21215-0036 Asian 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Footwear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Unknown Thai Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Hue T. Luu/Wife 293 North Van Buren Street, Rockville, MD 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Nov. 30 2011 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 30, arklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. Li Approximate Interval Between Poset and Death Immediate Cause (Final Ph_sician/ Gastro Intestina disease or condition resulting in death) day. Medical Examiner tracrania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ding physiciar Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the at detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe 1 be d à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 2 🗌 No Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 24 hours after death. Funeral Director; A 2 No Investigation Could not be Accident filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 hor **To the Fune** сотретеру fi 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 70144 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Car Dr Rockville, MD 20850

Registrar

DHMH 17 Rev 06-2011

State

Michael

31. Date filed (Month, Day, Year)

Murrou

NOV 2 9 2011

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mary Louise Tracey 3:00 a 2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick College View Center | If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth | Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) Funeral 1 🗆 M 2 🗙 F oct 7, 1924 Maryland 87 **Director** 219-14-9328 Usual Residence of Decede er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 10a. State within 72 hours after death with the Maryland 1 ☐ Yes 2XNo Taneytown Maryland Carroll 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral 21787 USA 2180 Trevanion Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 14. Race - American Indian Black, White, etc. by 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Schools Instructional Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mildred Mort Raymond Sharrer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2180 Trevanion Road, Taneytown, MD 21787 Randy L. Tracey, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/26/2011 Taneytown, MD Grace UCC Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Myers-Durboraw, Funeral Home 136 E Baltimore St, Taneytown, MD 21787 21. Signature of Funeral Service Licensee tour Part 1/2 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause or each line. Onset and Death Immediate Cause (Final disease or condition aroti Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner pementio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month Year in the past 12 n signed by the a 2 No g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 🗌 Yes 2 🗀 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural 5 Pending 1 🗌 Yes 2 🗐 No ☐ Accident Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Mb 21702

State Registrar 31. Date filed (Month, Day,

Year)

NOV 2

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day TESI Physician/ GIORGIO 7:20A DEC 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** P.G. ACCOKEEK 15444 OLD MARSHALL HALL RD. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 4-11-1925 570-58-0196 **Director** 86 ITALY 1 🕅 M 2 🗆 F Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland notified at Director 28a-f 1 Yes 2 X No MD. PRINCE GEORGE ACCOKEEK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 20607 U.S.A. 15444 OLD MARSHALL HALL ROAD death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ō 1 Never Married 2X Married þ 1 Yes 2
If Yes, Give
Year or Dates 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 'natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working NAT.SCIENCE FOUNDAT al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the U.S.GOVT. SCIENCE ADMINISTRATOR 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 PIA CIGHERI GIOVANNI TESI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15444 OLD MARSHALL HALL RD. ACCOKEEK, MD. 206 7 PATRICIA TESI-SPOUSE altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial ※☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 12-8-11 ALEX., VA. 21. Signature of Oneral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complication of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ALZHEIMER'S DISEASE disease or condition Medical resulting in death) Examiner HYPERTENSION Sequentially list conditions, Examine Dun to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and the burial-tra Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death the hed To the Hospital or Attending Physician: The law requires that the owithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ALZHEIMER'S DEMENTIA 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL FIBRILLATION 24a. Was an cate has page 2 autopsy performed? 1 Yes 2 No 1 Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No ္ဝ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury Natural 2 Accident 1 Yes 2 No Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 👿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 7, 2011 D0021173 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA 3460 OLD WASHINGTON R D #203 A WALDORF, NIRAN P. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

State

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2 0 | | 40206 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Day Physician/ Urizargamez PM ZON 1210 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Ballimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 □ M 2√5√F **Director** None 01/27/1984 Guatemala Usual Residence of Deceden show 10d. Inside City Limits 10a. State notified at 10c. City. Town or Location Director Yes 2 No 28a-f Md Hyattsville Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ed other than "natural", or items 23a on event, the Medical Examiner must be Funeral 20783 Guatemala 1413 Canahua St. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Guatemala Specify: Hispanic If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 9th Self Employed Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked ည Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev <u>once.</u> Mariano Urizar Barrios Rosalina Gamez de Urizar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberli Iliana Urizar/Sister 1413 Canahua St. Hyattsville, Md 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State General Cemetery 12/02/11 Guatemala 4 Donation 5 Other (Specify) John T. Rhines Funeral Home 3005 21. Signature of Funeral Service Lice. Name and Address of Facility St. NE Wash. 12th. D.C. 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final myelogenous lenhemia Physician/ Chronic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any hading he immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse luence of Exami and Due to (or as a consequence of): nding physician use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 5 Other (specify) Year Pregnant at time of death signed by the at id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 : To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 10 2 No 1 Yes 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shelley Sahu 11/18/11 P25679 -m0 Shelley Sahu ZZ Streen Street

State

Registrar

31. Date filed (Month, Day, Year)

NOV 29 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 | | |

	For State	5	State of Ma			nt of Health			0.0		100	00-		
	Registrar 1. Decedent's Name (F)	rst Middle, Last)	1		Sertificat	e of Death	_	2. Date of Dea	Reg. No.	H	3. Time of De	eath		
Physician/ Medical	Lyle Duane Verbeck							Month Day 2011 11:03 AM						
Examiner	4a. Facility Name (if not			1 North	4b. City	Town, or Location			4c. County		Arrando	1		
Funeral	5. Social Security Numb	er 6. Sex		(In yrs. last birth	day) If Unde	r 1 Year If Und	ler 24 Hrs.	8. Date of Birth	7 7 7	9. Birth	place (State or Fo	oreign		
Director	507-28-07		2 🗆 F	81 Y	rs. Months	Days Hours	Min.	pec. 13	^{Year} 1929	Ne	braska			
show tat	Usual Residence of Dec	b County Prince Geo	rgo s	10c. City, Town	or Location	Glenr	n Dale			1	10d. Inside City L	Limits		
Maryli 28a-f otified	rar yrand		rge s								1 ☐ Yes 2⁄4	∆ No		
Ind 21215-50036 It led within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at. O Be Completed by Funeral Director	10e. Street and Numbe 6829 Glei	wood Cour	t		10f. Zi	20769	9		10g. Citizen of V U	.S.A				
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rs after craft, or Examin			1 XYes 2 1 If Yes, Give Year or Dates.) 1951–53	1 ☐ Yes	2 🛮 No Speci	ify:		Specify:	Wh	ite 			
r1215-0036 ithin 72 hours after liene. r than "natural", o the Medical Exam Completed by	1 (Specify	5. Decedent's Educa only highest grade o			Decedent's Usu Give kind of wo	ork done during m	ost of working	g	16b. Kind of Bu	siness In	dustry			
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yland in the state of the state	17. Father's Name (First, Middle, Last) John Jacob Verbeek 18. Mother's Name Hazel								First, Middle, Maiden Surname) Lelle Nelson					
Mar Shou h and 7 is n traum	19a. Informant's Name Stephen	/Relationship (<i>Type, i</i>		19b. 10	Mailing Addres	s (Street and Num or Drive	nber or Rural i	Route Number	; City or Town, S	tate, Zip and	Code) 21032			
lore, I	20a. Method of Disposi	tion Cremation 3 Ren	noval from State	20b. Place of cemeter)	Disposition (Na , crematory or	me of other place)	•	ate	20c. Location -	City or T	own, State			
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Balti permit. Departr Imports any inji	21. Signatur Finera	I Service Licensee	Will	w		nd Address of Faculta ake of G		_				101		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
Physician/Medical	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										Onset and Dea			
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Box death ne a le ed for	in the past 12 mor 1 ☐ Yes 2 ☐ N 9 ☐ Unknown		4 Pregnant at 9 Unknown		5 Other (s				Mo	nth	Day Yea	ar		
Records, P.O. The law requires that the are has been signed by the page 2 should be detach. Completed by Phy	Part II. Other significa	nt conditions contri	buting to death b	ut not resulting in	the underlying	cause given in Pa	art I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown						
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Physic this can rall dire	1 Yes 2 Y	lo Hos	28a. Date of injur	ent 2 V ER/Our		28c. Injury at		ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred						
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Division of Vital Records, all or Attending Physician: The law requires a after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be Certificate: To Be Completed I		Guld not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, Medical Certificate: To Be (29a. Certifier 1 (Check 2	Certifying Physicia Medical Examiner: Certifying Nurse P	On the basis of ea	kamination and/or	r investigation, i	n my opinion, death	h occurred at t	the time, date a	ınd place, and du	e to the c	ause(s) and mann	ner stated.		
To the within To the comple	only one) 3 L		ractioner: 10 the	best of my knowl		oc. License numbe		e, and due to th	29d. Date signe					
	D	(enp			R104	317		- 11	23	12011			
XIX	30. Name and address	of person who com	oleted cause of de h	eath (Item 23a) (ale Col	type, Print)	rive XI	-A /	Annap	olis, m.	021	40/			
State Registrar	31. Date filed (Month, I	0V 2 8 201		r's Signature	back									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State RegistrateND#23ecor		-			Health and			011 40208		
			Registrate Name (First, Middle Decedent's Name (First, Middle)	Reg. No.	3. Time of Death								
	Physicia Medic		Brenda Elain	e Willi	.ams				er 21, 2	011 6:21 P.M			
ز	Examin	er	4a. Facility Name (if not institution 6726 Mink Cour	_	mber)		4b. City, Town, o	or Location of Deat ${ m rf}$	h	4c. County Char			
	Funeral Director		5. Social Security Number 240-90-3717	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			g. Birthplace (State or Foreign Country) North Carolina		
			Usual Residence of Decedent			147			pept. 1	ο, 1501μ			
	ryland -f sho ied at	ctor	10a. State 10b. County Marvland Charl			City, Town or Loc $aldorf$	cation				10d. Inside City Limits 1 ☐ Yes 2 X No		
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-	s 23a ust be	Funeral	6726 Mink Court				206	03		U. S. A	١.		
213-0030	permit. Page 1 and 2 should be filed within /2 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If feem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🛣 Divorced	Armed F	2 💢 No ive	l'	Nas Decedent of Information of Info	Hispanic Origin? (S an, Mexican, Puerl o Specify:	pecify Yes or No- o Rican, etc.)		e - American Indian, ck, White, etc. White		
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T Y	ould by mark mark		Claude Freeman 19a. Informant's Name/Relations		····	19h. Mailir	ng Address (Street	and Number or Ru			State, Zip Code)		
, Ma	nd 2 sh salth ar n 27 is er trau		Christopher Bry		/Son	1597	0 Coving	ton Road	, Brandy	wine, MI	20613		
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7	r this ceral direction	e: To	1 ✓ Yes 2 ☐ No 27. Manner of Death	28a. Dat	e of injury	ER/Outpatier 28b. Time of	28c. Inju	ry at	T	idence 6 Other			
0	ending sath. or: Afte he fun	ficat		igation	nth, Day, Year)	injury	M 1 🗆	rk? ☐ Yes 2 ☐ No					
DIVISION OF	after de Directe	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 28e. Plac	e of Injury - At ding, etc. (Spec	home, farm, str cify)	eet, factory, office			tion (Street and Number or Rural Route Number, or Town, State)			
	ne nospita n 24 hours ne Funeral pleted filled	Medical	(Check 2 Medical	g Physician: To the Examiner: On the b g Nurse Practioner	asis of examinat	tion and/or inves	tigation, in my opir	ion, death occurred	at the time, date	and place, and du	ue to the cause(s) and manner stated		
										29d. Date signed	ed (Month, Day, Year)		
ر			30. Name and address of person										
0	DC		YAHIA M	1.TAG	OUR	I 110	55W:	Nesip	Plla	plata 1	MD 2.646		
	Stat Registra		31. Date filed (Month, Day, Yar)	2011	Registrar's Sigi	B.	now				MD 2.646		

				Pleas	se Type or Pr							_	ole.				
		-	For State Registrar		State of IV	iaryian	•	artment of F rtificate of D		Mental H	ygien Reg. N	0.0			. 0 2 0		
1	1. Decedent's Name (First, Middle, Last) Physician/ GEORGE ARNOLD W.						N. SR	2. Date of D	eath		rear 13		ne of Death				
- 2	Medic Examin			not institution,	give street and number)	street and number) 4b. City, Town, or Location of De					NOVEMBER 21, 20				.00 P ···		
	Funeral	2	HARFOR 5. Social Security N		IAL HOSPITA		ast birthday)	HAVRE If Under 1 Year	DE GRAG	s. 8. Date of B	irth		RFO		ate or Foreign		
	Director		219-42-9 Usual Residence of		1 🕅 M 2 🗆 F	64		Months Days	Hou <i>r</i> s Mir	NOV 16)ay, Year) , 19	47	Cou	ntry)	RYLAND		
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	the Ma a or 28		MARYLAND HARFORD 10e. Street and Number					10f. Zip Code	GRACE		10g. C	itizen of Wh	at Cou		1 165 2 🗆 140		
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980	perfull for the strength of th	þ	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 ▼ Yes, 2 □ If Yes, Give Year or Dates.		No 1 Yes 2 No Specify:				.,				. Race - American Indian, Black, White, etc. pecify: BLACK				
5-0	72 hour	Completed	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind							Kind of Business Industry			
213	within giene.		Elementary/Seconday (0-12) College (1-4 or 9			5+)		O NOT use retired) L & PARTS	SUPPLIE	ŒR		US GOV	ÆRI	IMEN'I	יַ		
CCC	drice be filed antal Hy ked oth	To Be	17. Father's Name (GEORGE		*		18. Mother's Name (First, Middle ESTELLA VIRGIN						·				
/300 Maryland 91915-0036	should and Me is mar aumati		19a. Informant's Na	ame/Relationshi	p (Type, Print)			ng Address (Street	and Number or F	Rural Route Numb	er, City o	or Town, Sta		,			
	and 2 Health Item 27 other to		20a. Method of Disp		N (WIFE)	20b. F		VILLAGE]	DRIVE, E	IAVRE DE	_	CE, MA					
121/11 Raltimore	Page 1			Cremation 5 Cother (Sp	3 ☐ Removal from State pecify)	e c	emetery, cre	matory or other place	GRD 12	2/1/11		ABERDI					
11/12/11	permit permit Depart Import any inj once.		21. Signature of Fu	neral Service Lic	censee	2 m	2	2. Name and Addres	ss of Facility	RAL HOM	E, P	.A.		D 04	070		
Ì	–Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung CANCER Due to (or as a consequence of):														
S	Examiner	niner	MRSA BACTEREMIA										_				
NOO	ت. تع وه تا تع	lical Examiner	Cause (Disease or that initiated event resulting in death)	iinjury s	cDue to (or as	a consequ	Jence of):								-		
9. WALL	the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. This 24 hours after death. The 24 hours after death. The 24 hours after death. The 24 hours after death are this certificate has been signed by the attending physici mpleted filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of o	aldeath 3 L	Ectopic pregnand Other (specify)	y			23d. Date Mont		ery Day	Year		
9 0	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to t														
63	require been si	leted	7	erten	SION CLOO	h /	101/01	4	-			,			Unknown		
GEOR!	Physician: The law this certificate has ral director, page 2:	Completed by	Obstructive Sleep ApNeA 24a. Was an autopsy prior to content of the content of t								or to co ath?	mpletion	of cause of				
	sician: sicertific	To Be	25. Was case referrexaminer?	ed to medical	Hospital:	tiont 2 🗆	ED/Outpatia		ace of Death (Ch			a 🗆 au					
90 00	orl or	Certificate: T	27. Manner of Deat 1 X Natural 2 Accident	h 5 Pending Investiga	28a. Date of inj (Month, Date)	urv	v 28b. Time of 28c Injury at 28d Describe how follows accurred										
Divioi	ol or Atte		3 Suicide 4 Homicide	6 Could n determin		jury - At ho tc. (Specify	y - At home, farm, street, factory, office (Specify) 28f. Location (St City or Town					treet and Number or Rural Route Number, n, State)					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	Check 2	∠	Physician: To the best o aminer: On the basis of Nurse Practioner: To the	examinatio	n and/or inves	stigation, in my opinic	n, death occurre	d at the time, date	and plac	e, and due to	the ca	use(s) and	d manner stated		
_	To th withii To th comp	-	29b. Signature and		. /	1 (29c. License	number		29d. D	ate signed (/	Month,	Day, Year	,		
			30. Name and addr	ess of person w	ho completed cause of	death (Item	23a) (Type I	Print)	3072			renter		30,0	2011		
	4+1VA		ADURV	A Des	41 501 S.	UNIO	N AVO	· HAVE	deGR	Ace, M	D.	2107	18				
	Stat Registra		31. Ďate filed (Mont	DEC 05	2 2011 32. Regist	rar's Signa		park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death November 25 Physician/ Sarah Mildred Wimsatt 2011 8:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Hospice Care Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Year) Months Hours 577-22-0865 89 **Director** 1 M 2 X F June 24 1922 Ohio Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified a Maryland Montgomery Derwood 1 🗌 Yes 2 🏖 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18002 Mill Creek Drive 20855 United States ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: If Yes, Give 3 🛮 Widowed 4 🗆 Divorced White Year or Dates ed other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Sharkey Carrie Lou Raines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Wimsatt / Son Department of Health Important: If item 27 any injury or other to once. 2537 Salem Bottom Road, Westminster, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗹 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 11/27/11 Metropolitan Crem. Alexandria, Virginia 2. Name and Address of Facility
Muriel H. Barber Funeral Home
P.O. Box 5038, Laytonsville, 21. Signature of Funeral Service Licenses 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ CVA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy igned by the atter 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes Hospital or Attending Physician; 24 hours after death. the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗹 Natural 5 Pending injury work? 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat@re and fit 29c. License number R 143201

State Registrar

 θ'

DHMH 17 Rev 06-2011

6001 Muncaster Mill Road, Rockville, Maryland

20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

CRNP

Debrah Miller,

31. Date filed (Moi

State of Maryland / Department of Health and Mental Hygiene 20 for State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death November 24. 2011 Physician/ Howard Whidden 10:55P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Fort Washington Hospital Fort Washington If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours New Hampshire 1 K M 2 🗆 F 3/27/1928 003-12-0882 83 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director notified 1 ☐ Yes 2 ♣ No Maryland Prince George's Fort Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 ms 23a or must be r Funeral 13214 L'Enfant Dr. USA 20744 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No 9 þ 1 Never Married 2XXMarried permit, Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any righty or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 XYes 2 ☐ No Specify: Specify: White Completed 3 Divorced 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) Central Intelligence life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Agency Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Whidden Haze1 Harwood Maurice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13214 L'Enfant Drive Ft. Washington, Maryland 20744 Natalie Whidden - Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🗌 Burial 2 🔲 Cremation 3 🐔 Removal from State cemetery, crematory or other place, 11/28/2011 Manchester, NH Pine Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 6160 Oxon HI11 Rd. Oxon HI11, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer and Immediate Cause (Final Physician/ MOXIC .2 disease or condition Medical resulting in death) Examiner 4 did Dulhan oequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami こくてら -tran and Due to (or as a consequence of): resulting in death) Last the burial-Physician/Medical eno To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day ☐ Pregnant at time of death ☐ Unknown ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work s after death.

I Director: Af
d in by the ful 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signatu e and title of certifie 00056565 30. Name and address of person who com pleted cause of death (Item 23a) (Type, Print) W.D. 11711 Livingston Rd., Ft. Washington, MD 20744 Samuel Kleiman, 31. Date filed (Month, Day, State NOV 2 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

DHMH 17 Rev 06-2011

State

9801 Georgia Avenue, #117, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shyamsundar Rajan, MD

NOV 2 9 2011

31. Date filed (Month, Day, Yea,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | Amended items For State Registrar #4c,10b,per f.h/physician, WCHD Certificate of Death 11/29/11 E.T. Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 11/25/2011/ear 10:17 A M Physician/ Willis J. Windsor, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Worcester Somerset 33024 Costen Rd. Pocomoke City Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 217-52-0649 **Director** 1 🛛 M 2 🗆 F 5/28/1946 MD show must be notified at 10a State 10c. City. Town or Location 10d Inside City Limits Director Somerset 28a-f 1 Yes 2 XNo MD Pocomoke City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a USA 21851 33024 Costen Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? WINDSOR Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer Public Safety Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willis J. Windsor, Sr. Mildred E. Tawes Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106 Bypass Rd., Pocomoke City, MD., 21851 Carol Troast/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Pk. 11/30/2011 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home P.A. ignature of Funer 107 Vine St., Pocomoke City, MD, 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician PROSTATR CANCERA MALIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events -trar Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home Residence 6 Other (Specify Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State 24 hours a Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier DO05 8400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAcisBuly no 21802 RA 10 GHURM. WAR 31. Date filed (Month, Registrar's Signature, State 2011 NOV 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 10b per fb 9922 12-14-11 sm dental Hygiene
State of Maryland Department of Health and Mental Hygiene 40214 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Osborn Williams 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death WM Regional Medical Center Cumberland Allegany Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours Month Day Year 5/27/48 Country) 236-76-5192 Director 63 Usual Residence of Decede 10b. County Hampshire 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Allegany Springfield 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral P.O. Box 441 permit. Page 1 and 2 should be filed within 72 hours after death with 26763 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) maintenance Housing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles E. Walker Helen M. McDougle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Grimes/friend HC 65, Box 1800, Springfield, WV 26743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth Date 20c. Location - City or Town, State 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 15/11Scarpelli Crematori Cresaptown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funeral Home, Inc. P.O. Box 912 Keyser, 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due to (or a a consequence of disease or condition resulting in death) Streptococcus Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be adenocarcineme of be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabe Type II Dia 25. Wa case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify, Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 Natural injury ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 11-15-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ∀agnoni 902 Seton Dr., Cumberland, MD 21502 Christopher 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 2011 Alice Ida Yommer Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital ge (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Year If Under 24 Hrs. **Funeral** Country)
Mary Land (Month, Day, Year) 01-08-1934 1 □ M 2 🗶 F 214-34-1559 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10a. State 10c. City, Town or Location Completed by Funeral Director 1 Yes 2 No MD Montgomery Olnev 10g. Citizen of What Country? 10f. Zip Code 20832 19416 Olney Mill Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 💢 No If Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) own home Homemaker Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Hannah Elizabeth Williams Hager Orval William Hager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19416 Olney Mill Road Olney, MD 20832 Joseph Yommer husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 12-10-2011 Frostburg, MD 4 Donation 5 Other (Specify) Frostburg Mem Park 22. Name and Address of Facility Sowers Funeral Home, P.A. 60 W. Main St Frostburg, MD 21532 21. Signature of Funeral Service Licensee Han M00547 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 30 minut Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ous to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes ∠ œ 9 ☐ Unknown the ned by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signe page 2 should be o 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No certificate Yes 2 No 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 FR/Outpatient 3 I DOA မ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation Accident 24 hours after deat Funeral Director: 6 Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 PCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 9 00068488 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 9901 Medical Cor Dr Rockville 31. Date filed (Month, Day, Year) 32. Registrar's Signature BEC. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Decth Alford 10° 2011 12:21P M Alan Gerard Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NA 5624 Loch Raven Blvd. Baltimore Social Security Number 9. Birthplace (State or Foreign Country) M.D. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 7. Age (In yrs. last birthday) 1 X M 2 - F 03-09-67 154-66-6010 **Director** 44 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Y Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5624 Loch Raven Blvd. 21239 items ? permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc.African à 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced SpecifyAmerican Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) University Hospital 12th Grade Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Alford, II Gwendolyn Walker Chenal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Pennsylvania Avenue Apt.#812 Balto; MD Gwendolyn Riley-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Garrison Forest 12-20-11 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 Gilmor Štreet Baltimore, MD 21217 Ν. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ -nD disease or condition resulting in death) Medical Examiner Sequentially list conditions cause. Enter Underlying Exam Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 No. မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 V Natural injury 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar NORTH GRE

who completed cause of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 Physician/ ADENIJI 0.S. BOLAJOK O Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK MARYLAND HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Days Hours Months 271-56-9561 64 NIGERÍA 1947 Director Usual Residence of Decedent r 28a-f show notified at 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No FREDERICK FREDERICK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 must be r Funeral 21702 PIKE 1621 OPOSSUMTOWN. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S "natural", or item ledical Examiner n 11. Marital Status Armed Forces Black White etc. 1 Yes 2 No þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 XDivorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 16b. Kind of Business Industry 16a, Decedent's Usual Occupation 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) PRIVATE MENTAL HEALTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MORINOLA AWODEINDE ပ EMMANUEL ADENIJI 19b. Mailing Address (Street and Number of Rural Route Number City of Jown State Zin Code) 3412 CURTIS DRIVE #105 TEMPLE HILLS, MARYLAND 20746 19a. Informant's Name/Relationship (Type, Print) LATEEF AKANDE/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition GATE OF HEAVEN XIX Burial 2 Cremation 3 Removal from State SILVER SPRING, MARYLAND 12/17/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B.JENKINS FUNERAL HOME, INC. 21. Signature uneral Service Licensee any inj 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Vere) Medical Due to (or as a consequency of Examiner Sequentially list conditions, Examiner Due to or as a consequence of) if any leading to immedicause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and that initiated events Due to (or as a consequence of) resulting in death) Last s been signed by the attending physician should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 2 🛛 No g 🗌 Unknown a Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown Pneamonia, 1 Yes 2 No Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 cate has t page 2 s 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 XNO Other: Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this c 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident Suicide Investigation pleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the pasts of examination and/or investigation, if my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Carol Santelmann Arban Physician/ Month 2011 December 7:05P Medical 4a. Facility Name (if not institution, give street and number)
13433 Stowaway Court 4c. County of Death Examiner 4b. City, Town, or Location of Death Solomons Calvert If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) DC Social Security Number 579-46-8020**Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 M 2 K F Days Hours 1270474934 Director Yrs Usual Residence of Deceden 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director ems 23a or 28a-f sh r must be notified a MD Calvert Solomons 1 Yes 2X No 10e. Street and Number 13433 Stowaway Court 10f. Zip Code 20688 10g. Citizen of What Country? USA iral", or items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2XX No If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 ☐ No Specify: Specify: White "natural" 3 Widowed 4 X Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Item 27 is marked မ Rudolph Santelmann Mildred Kaiser permit. Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CJ Arban FitzHenry/Daughter 13405 Melville Lane, Chantilly, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Chesapeake crematory 12/14/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Maryland Cremation Services PO box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall 16llasha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ small cell lung concer disease or condition resulting in death) MARTHE Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a donsequence of). attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death n signed by the at Id be detached for 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed: 2 🗌 No Yes 2 No 1 Tyes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗷 No Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse: Practioners To the best of my knowledge, death oncurred at the time, date and place, and one to the cause(e) and manner as state 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D56024 December 13 2011

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital

Swite 110

Prince Frederick HI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Koad

32. Registra s Signature

Kenneth L. Assort

6 2011

31. Date filed (Month, Day, Year)

Physician /Medical **Examiner** requires that the death certificate be executed

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

7 is marked other traumatic event, II

27 is r

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1 and 2 should be f Health and Mental

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permit, Page Department o Important: If any injury or

Director

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Baltimore.

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Medical

State Registrar

/Medical

Examiner Physician/Medical

burial-trar as use for page 2 certificate this funeral hours after death.

1 Yes 2 No 27. Manner of Death 1 Natural

Completed Be Certification: To 4 Homicide

29a. Certifier

(Check only one)

25. Was case referred to medical

∠ □ Accident 3 ☐ Suicide

29b. Signature and title of certifier

investigation 6 ☐ Could not be

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mason Mi) 9005 Caton Ave Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 13, 2011 Physician/ Osgi Akdemir 9:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Manor Care-Bethesda Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 1 🗆 M 2 🕱 F Min 223-43-4370 March 25, 1931 Turkey 80 **Director** Usual Residence of Decedent 28a-f show 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Montgomery Silver Spring 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13006 Carney Street 20902 Turkey be filed within 72 hours after death ed other than "natural", or items event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Malden Surname) ည Asadur Ozkan Ayva Akbilek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Nick Vahanian/Son 9654 NW 47th Court, Polk City, Iowa 50226 other i Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot Fort Lincoln Cemetery or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State December 17 4 Donation 5 Other (Specify) Brentwood, Maryland 2011 Pumphrey Funeral Home/ 2. 7557 Wisconsin Avenue 22. Name and Address of Facility Robert A. P Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses Lou M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac Arrest 10 months disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Atherosclerotic Heart Disease years Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical death certificate be P.O. Box 68760 the attending p for use as t IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 2 🗶 No cate has been signed by the apage 2 should be detached 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
 Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Failure to Thrive Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 2 X N Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 🕱 No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No ☐ Accident☐ Suicide Investigation M the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Newse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 460

Registrar DHMH 17 Rev 7/2009

State

10810 Darnestown Road, Suite 202, Gaithersburg, Maryland 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman Tuli, MD

31. Date filed (Month, Day, Year)

December 13, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death 8:24 P M ĨÔ 2011 December Barbara Ann Anderson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Hospice Casey House Rockville 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) (Month, Day, Year) Days Hours Min 385-40-6011 71 1 🗆 M 2 🕱 F August 1, 1940 Indiana Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 United States 8705 Victory Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces? 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph H. Ruhmkorff P. Corrine Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8705 Victory Lane, Potomac, Maryland 20854 Lee E. Anderson / Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Montgomery Crematorium, Inc. 1 Durial 2 X Cremation 3 Removal from State December 15 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Sign, ture or sun mil Survice Robert A. Fumphrey Funeral Home, Roc 300 W. Montgomery Avenue, Rockville, Rockville, Inc Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic Cancer disease or condition resulting in death) Due to (or as a consequence of):

Physician/ Medical **Examiner**

attending physician

signed by

has

after death. Director: After

within 24 hours a

To the Hospital or Attending Physician: The law requires that the death certificate be

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Examiner

Funeral

Director

shov

ms 23a or 28a-f sho must be notified at

Examiner

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n and Mental Hygiene.
7 is marked other than "r

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Department of Important: If it any injury or o once.

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within 72 hours after death

Baltimore, Maryland 21215-0036

Director

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Completed

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Physician/Medical Examiner the burial-tran as 9 Completed page 2 funeral director, Certificate: To Be filled in by the Medical

Sequentially list conditions, if a y, hading to min south cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of): d										
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year									
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 🕱 No 3 🗆 Probably 4 🗀 Unknown								
		24a. Was an autopsy performed?									
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 🗌 Yes 2 🔀 No	Hospital: 1	Home 5 Residence	6 🛭 Other (Specify) Hospice								
27. Manner of Death 1 🕅 Natural 5 🗌 Pending 2 🔲 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 1 Yes 2 No	28d. Describe how inj									
3 Suicide 6 Could not 4 Homicide determined		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)								

1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D63195

29d. Date signed (Month, Day, Year)

December 11, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Wilks, M.D.

6001 Muncaster Mill Road, Rockville, Maryland 20855

31. Date filed (Month, Day, Year) 16 2011 DEC

2 3 29b. Signature and title of certifie

29a. Certifier

Registrar's Sign

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ December 15 12:44 2011^a **a**. M Edith Y. Brooks Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Min (Month, Day, Year) 238-46-1156 80 1 □ M 2 🕅 F Director 4-2-1931 NC Usual Residence of De 28a-f show 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Director must be notified 1 Yes 2 XNo MD Baltimore Gwynn Oak 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral 7104 Yataruba Drive 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Examiner Armed Forces Black, White, etc. 0 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Giant Food, Inc. Buyer 2 should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ≗\$anuel Young Mattie Young Philpott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) age 1 and 2 slint of Health at: If item 27 is LaQuita B. Gilfillian/ Daughter 102 Sonesta Court, Sewell, NJ 08080 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 12-19-2011 Oxford, NC Stovall Baptist Church 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Hunaral Safe 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mechanis Immediate Cause (Final Ph si ian 9 110 disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the attending p IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the a 1 Yes 2 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 № No 3 Probably 4 Unknown 1 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed Yes 2 nas certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ⊑ Yes 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After I completely filled in by the funer 5 Pending Yes Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO V HARURS MM 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40224 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ 10:0₀a M Michael Blick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death **Examiner** 3512 Carbenas Ave 7. Age (In yrs. last birthday) 56 yrs 5. Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min (Month, Day, Year) Country 218-60-3097 Director MD /9/55 Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD N/A Baltimore X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō iral", or items 23a o Examiner must be 21213 USA Funeral 3512 Carbenas Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1X Yes 2 No 1980

If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 frican 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates Amer the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) Landscaping College (1-4 or 5+) Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 James Blick Elsie Blick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3512 Carbenas Ave, Balt., MD 21213 Teariha L. Washington/Daug. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12/24/11 Balt.,MD 4 Donation 5 Other (Specify) Bayview Crematory 2. Name and Address of FacilityHari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 22. Name and Address of Facility Hari P. . Signature of Funer Service Lightneed 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Can disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Day Year 5 Other (specify) Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 \(\triangle \text{ Nursing Home 5} \) Residence 6 \(\triangle \text{ Other (Specify)} \) <u>1</u>2 Hospital: 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 5 \square Pending Natural 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) **DEC 16 2011**

N. charles of

701

32: Registrar's Signature

, Ste 4105 Baltumore, MD 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#17 per FH, G922, 12/16/2011 WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 40225 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month / 2 Physician/ 4:35 2011 Medical 4c. County of Death 4a. Facility Name (#not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Himore 24 Hrs. Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 X M 2 □ F **Director** 6-10-1946 Washi Usual Re sidence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Amore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21206 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify: Black Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event **L-*** Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed Be Father's Name (First, Middle, Last) Unk. 18 Mother's Name (First, Middle, Maiden Surname) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2011 Rafae Arei Balton MD lontera-6311 Walther 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 12/15/2011 Baltimore, MA onation 5 Other (Specify) 17H East 1101 E. North Ave e of Funeral Service Licensee March 22. Name and Address of Facility Signat 21202 Part 1. Enter the disease, or complications that caused the death(oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a ch line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 1 Yes 2 No Division of Vital Records, Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform has death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 🗓 filled in by the funeral director, 25. Was case refer -d to -dical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann 28b. Time of of Death 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural work?
1 \sum Yes 2 \sum No Investigation Accident Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29c. License number 29d. Date signed (Month, ause of death (Item 23a) (Type, State Registrar

11-09309 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Thomas Baker, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ William Thomas Baker, Jr. **Medical Examiner** 1750 hrs December 10, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A **Baltimore** 1211 West North Avenue 3rd Floor If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) VA 6/2/58 Months Davs Hours Min. Director unk 53 1X M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count Baltimore MD N/A 1 Yes 2 No or 28a-f show Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: Hitem 27 is marked other than "natural", or items 23s or 28s-f sho
righty or other transmite event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10e. Street and Number 2739 Baker St. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White etc.
African
Amerr If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 1 Yes 1 Yes 2 X No specify: 3 Widowed 4 Divorced f Yes, Give Year Specify: Ď 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Food Elementary/Secondary (0-12) Laborer 17. Father's Name (First, Middle, Last) William Thomas Baker, Sr. 18.Mother's Name (First, Middle, Maiden Surname) Julia White Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2739 Baker St., Balt., MD 21216 19a, Informant's Name/Relationship (Type, Print) 2739 Baker St., Balt., MD Katie R. Baker/Sister 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Bayview Crematory 1 Burial 2 X Cremation 3 Removal from State 12/19/11 Balt.,MD 4 Donation 5 Other Specify. 21. Signat re i Funeral ervice License 22. Name and Address of Facility Hari P. Close For Syst PA 5126 Belair Rd, Balt., MB 21206-5105 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Medical line. Streptococcus pneumonia sepsis complicating Malignant Lymphoma Between Onset and failure. List only one cause on each line, Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and red for use as the burial - transi The law requires that the death certificate be executed Physician/Medical 23a,27 per me g924 2-2-12 vt X UNPENDED **AMENDED** Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. <u>á</u> 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been sfuneral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed 1 ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Director: d in by the f 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E December 11, 2011 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Agnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Physician/ ELEN Medical 4c. County of Death Harford County Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner House of Jubilee Assisted Living Fallston 5 4 1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year,
July 5, 1 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-22-9364 Maryland 1927 Director 1 □ M 2 🗶 F 84 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits aţ 10a. State Director items 23a or 28a-f s ner must be notified 1 ☐ Yes 2 X No Sykesville Maryland | Carroll County 10f, Zip Code 10e. Street and Number 10g, Citizen of What Country? 21784 USA Funeral 6311 Oakland Mills Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner rmed Forces? Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 X Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Residence Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Helen DeShield Schutt John Joseph Hyle other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other 2101 Haverbrook Drive, Fallston, Maryland 21047 (Son + P.R.)Marc A. Burgard 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Green Mount Crematory 12/19/2011 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signati / of Funded Service Life MYTCHECL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death rembose Phylician disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions if any, leading to immediate cause. Enter University of Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami executed and Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 the phy use as attending r IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Dav Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy certificate Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of I Director: After the din by the funers Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work? 2 🗌 No hours after death Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ess of person who completed cause of death (Item 23a) (Ty 31. Date filed (Me 6 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician/ Hazel Olivia Bell 2011 ecember Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot Genesis Health Care The Pines Easton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 237-12-9163 1 🗆 M 2 💢 F 09/08/1920 91 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location Director MD Easton Talbot 1 X Yes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country' ō "natural", or items 23a or edical Examiner must be Funeral 21601 USA 640 MecKlenburg Avenue, Apt. 112 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Deceding
Armed Forces?
Yes 2 No 11. Marital Status 1 Never Married 2 Married Ď Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 □ Divorced is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Hairdresser Service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bender Department of Health and Menta Important. If item 27 is marked any injury or other traumatic evonce. ည Maude Α. William Α. Sayers 19a. Informant's Name/Relationship (Type, Print)
Dessie Cunningham/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28096 Baileys Neck Road, Easton, MD 21601 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 12/16/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Mary Tand Tremation Services
PO Box 1413, Baltimore, MD 21203 Signature of Funeral Service Licenses QYOL a Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Due to (or as a conse Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 1 Yes 2 9 Unknown signed by the atte Pregnant at time of death Other (specify) No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has b Il director, page 2 sl autopsy perform death? Heme 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) e Funeral Director; After this releted filled in by the funeral di 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2, To the F complet only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12-15 ted cause of death (Item 23a) (Type, Print) 30. Name and a ress of person who d 32. Registrar State

Registrar

6

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Continued of Posth 40229 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3. Time of Death Month Year 2225 PM Physician Brockmeyer December 2011 Helen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** N/A Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Jan. 7,1937 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 🖼 F Maryland 217-34-8561 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Baltimore Co. Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 934 Elton Avenue United States 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ⅓ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I Marie Handlir Frank Krebner ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Anthony F. Brockmeyer 4230 Wolf Hill Drive Hampstead, Maryland 21074 Health attem 27 i or other Department of Heal Important: If item 2 any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 12/13/2011 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland Sacred Ht. Of Mary Cem. 21. Signature of Funeral Service Ligenses Duda-Ruck Funeral Home of Dundalk, Inc. 21222 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Embolim Physician vierial disease or condition resulting in death) /Medical to (or as a consequence of) Examiner sche Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts.) Examine ctrok or Attending Physician: The law requires that the death certificate be executed physician and stransil Emboliz that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) detached 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has b director, page 2 s 2 No 1 ☐ Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death Check on one Be examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury М 1 🗌 Yes 2 🗌 No 2 Accident Director: A id in by the f Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 8,2011 165-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sophie 4940 Eastern Avenue, Baltimore, MD, 21224 Well S

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 1 6 2011

A. par

rec's Signature

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician/ Month 12 2011 5:30PM 4 <u>Katherine Huffington Bird</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Eldersburg Carroll 2814 Kaywood Place If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Sept 25, 1922 Maryland 217-12-3885 89 Director 1 □ M 2 🗶 F Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2X No MD Carroll Eldersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral items 23a 21784 USA 2814 Kaywood Place death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify. "natural", 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Decorating <u>Owner</u> permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Pearl Russell Elmer Warren Huffington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Bird/son/POA 5215 Ilex Way Dayton, MD 21036 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 12/16/11 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Commation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature Ineral Service License Soing Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final MO Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Other (specify) Pregnant at time of death been signed by the a should be detached Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation Accident 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and ti

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Physician/ Brooks 13 а м Clifton W. B:05 Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Clinton Southern MD Hospital 8. Date of Birth (Month, Day, Ye If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Wash. DC 579-08-0668 Director May 30, 1968 43 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at Director Yes 2 □ No Charles Indian Head 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20640 23a 1825 Budds Ferry Pl. ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) the Private Entrepreneur event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot rother traumatic even မ Helen Price Rev. Alphonzo Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 1825 Budds Ferry Pl. Indian Head, MD 20640 Rev. Alphonzo Brooks/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ە <u>∓</u> ە 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 12-21-2011 Suitland, MD 22. Name and Address of Facility Ronald Taylor II FH 21. Signature of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line ANDRECTAL Onset and Death Immediate Cause (Final CANCER Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Month Dav Year Pregnant at time of death 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEACIEN CY SYNDROME IMMUND 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown is certificate has been significate, page 2 should b ANEMIA KIDNEY FAILURE, 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director; Al Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 💇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one and title of certi 29d. Date signed (Month, Day, Year) 29b. Signature ATTENDING 12-14-2011 D 52900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MVSA MOMOH MD, 12150 ANNAPOLLS ROAD # 205, GLENN DALE MO 31. Date filed (Month, Day, Year) 32. Registrar's ignatur 1 6 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN DITEM#23a, pt1, II per PHYS, G922, 12/16/2011, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2011 Month December 11, 2:55 PM Physician/ Jean Louise Bone Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Baltimore Towson If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Days Hours Min Apr 16, Year 1951 60 Maryland 220-54-7434 Director 1 □ M 2 😿 F Usual Residence of Decedent 28a-f shov 10d. Inside City Limits at 10a. State 10b. County 10c. City. Town or Location Director notified 1 Tes 2 KNo MD Baltimore Parkville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ò must be 23a Funeral United States 21234 8113 Ridgely Oak Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. 0 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher's Aide Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, and Mental ၉ Anne Charlotte Burnham James Robert Kelly other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 8113 Ridgely Oak Road Parkville, MD 21234 Daniel Maurice Abbott, III /Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Dec 12 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Beltsville, Maryland Chesapeake Crematory 2011 Name and Address of Facility

Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee M01443 8717 Green Pastures Drive Towson Maryland 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Sepsis** Approximate Interval Between Onset a d Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a co **Examiner** Perforated Bowel if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transit executed Incarcerated Hernia Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical I or Attending Physician: The law requires that the death certificate be earlier death.

Director: After this certificate has been signed by the attending physicia Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ jo in the past 12 months' Day 1 Yes 2 9 Unknown be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Colon Cancer Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should ! Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page 2 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Hoxpic 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ar MD 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE SULTE 4105 6701 NCHAKLES ST KUMAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:40 P.M 2011 December Billie Marie Beltran Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Montgomery Hospice Casey House If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year, Days Hours Min Months Director 219-44-8226 1 M 2 🕱 F Maryland August 5, 1943 68 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location with the Maryland Director notified 28a-f 1 Yes 2 X No Maryland | Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò ms 23a o must be Funeral United States of America 20874 21000 Father Hurley Blvd., Apt. #421 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14. Race - American Indian ed other than "natural", or itel event, the Medical Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Law Firm Legal Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Helen Sage Archer M. Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13119 Diamond Hill Dr., Germantown, MD 20874 Stephen C. Beltran / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) December 16, ☐ Burial 2 K Cremation 3 ☐ Removal from State Department o
Important: If
any injury or
once, ō Bethesda, Maryland Montgomery Crematorium, Inc. 4 Donation 5 Other (Specify) 2011 Robert A. Pumphrey Funeral Home/Rockville, Inc. B00 W. Montgomery Ave., Rockville, MD 20850-2805 Signature of Funeral M00896 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗀 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ate has page 2 s autopsy performed? Yes 2 🔀 No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Stother (Specify) Inpatient 2 🔀 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation hours after death I Director: And in by the f Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in by Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29h Signature

101

Registrar
DHMH 17 Rev 06-2011

State

Debrah Miller, CRNP, 6001 Muncaster Mill Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC

1 6 2011

R143201

16:23 PM

Georgia

10d. Inside City Limits

1 X Yes 2 □ No

2011

N/A

Birthplace (State or Foreign Country)

White

Approximate Interval Between Onset and Death

12 Hours

MONTHS

Day

2 No

Year

Month

1 Yes

4940 Eastern Avenue, Baltimore, MD, 21224

Steel

State Registrar

DHMH 17 Rev 1/2001 11595

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-09289 State of Maryland / Department of Health and Mental Hygiene Timothy Jordan Christensen Certificate of Death 1. For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 10, 2011 0106 hrs Christensen Jordan Timothy **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Jacksonville Jarrettsville Pike and Sweet Air Rd If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs Hours Months country) Mary land June 10 1991 Director 213-33-1694 20 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No Baltimore Lutherville Maryland or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examinar most headers. Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code U.S.A. 21093 1006 Adcock Road 14. Race - American Indian, Black, uneral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes White 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year Specify: É 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Baltimore, MD 21215-0036 12 3 Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elisabeth Steele Colonell Richard Lee Christensen, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lutherville, Maryland 21093 1006 Adcock Road Elisabeth Bracken / Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State HilltopServicecorp 12/16/2011 Towson, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Funeral Se vice Linear Towson, Maryland 21204 1050 York Road 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED has been signed by the attending physician 2 should be detached for use as the burial -Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? Yes 2 No 1 🗸 Yes 2 No After this certification funeral director, 1 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 1 Yes 2 No 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Driver auto fixed object collision FOUND: Natural 1 Yes 2 ✔ No Pending Director: d in by the f hours after death. Dec 10, 2011 0056 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) Jarrettsville Pike and Sweet Air Rd, Jacksonville, MD .m 24 hou. • Funeral D determined (Specify) Local Street Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 10, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Manth Day, Year) State ark

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

an/	State Registrar 1. Decedent's Name (First, Middle, L	Last)		Cer	tificate o	Death		2. Date of Deat	h Day	Year	3. Time of
an/ cal	Sadie C. Crone							12-12-2	011		5:50F
ner	4a. Facility Name (if not institution, g	give street and number))		4b. City, Town	, or Location	of Death			unty of Death	
	Gilchrist 5. Social Security Number 6	5. Sex 7. A	Age (In yrs. last	(a inthoday)	Tows		24 Hrs	8. Date of Birth		Baltin	
	218-10-6469	1 M 2 X F		Yrs.	Months Day		Min.	(Month, Day,		Gou.	nplace (State o ntry)
	Usual Residence of Decedent		95					9-18-1	.916	Massa	chuset
tor	10a. State 10b. County			own or Loc							10d. Inside Ci
Director	Md. Balti	more		Notti							1 🗆 Yes
la	10e. Street and Number				10f. Zip Code					of What Cou	intry?
Funeral	4718 Ballygar	Road 12, Was Deceden	t Ever in U.S.	13. V	Vas Decedent o	236 f Hispanic Ori	ain? (Spec	ify Yes or No-		ISA Race - Ameri	can Indian.
by F	1 Never Married 2 Marrie			If	Yes, specify Co	ıban, Mexicar	n, Puerto F	Rican, etc.)		Black, White	, etc.
	3 ₹ Widowed 4 □ Divorced	If Yes, Give Year or Dates.		1	Yes 2 🗓	No Specify.			Spe	ecify: Wh	nite
Completed	15. Decedent's (Specify only highest			(Give k	ent's Usual Occ and of work dor	e during mos	t of workin	g		of Business/I	
E l	Elementary/Secondary (0-12)	College (1-4 o	r 5+)		ONOTuse retire eteria	,				ic Sch	_
Be (17. Father's Name (First, Middle, Las	st)						(First, Middle, N			
မ	Joseph Lepak	,						ne Ler		,	
	19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailin	g Address (Stre			Route Number,		vn, State, Zip	Code)
	Susan Gordon	DT	R.		7 Doub1					e, Md.	
	20a. Method of Disposition 1	3 ☐ Removal from Star	te St.	ce of Dispon netery, crem Mich	sition (Name of natory or other p ael Lut	h. Cem	12-1	ate 6-2011	20c. Locat Balti	ion-City or I	Town, State
	21. Signature of Funeral Service Lice				Name and Add		^{ty} Sch Road	nimunek Notti		cal Hor	
	23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	ly one cause on each li		741	r the mode of d						Approximat Interval Bet Onset and
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequer								
Med	IF FEMALE:										
Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant	23c. If yes, outcome of pregnancy 1					23d. Date of deliv Month			very Day
ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										the cause of do
Completed								24a. Was a	sy		opsy findings ompletion of o
								perform 1 Tes	2 No		29 No
Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			_ 10	Place of Dea			X		1) . 0
은 ::	27. Manner of Death	1 L Inpa	atient 2 LEF	R/Outpatien Bb. Time of	t 3 🗆 DOA	4 ⊔ N	-	ne 5 Reside			W Heir
cat	27. Manner of Death 28a. Date of Injury 28b. Time of work? 28c. Injury at work? 1 Accident Investigation 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred										
Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ot be 28e. Place of Ir	njury - At home etc. (Spec <i>ify</i>)	e, farm, stre	et, factory, offic	e	2	28f. Location (St City or Town		amber or Rura	al Route Numb
Medical C	(Check 2 Medical Exa	Physician: To the best of aminer: On the basis of	f examination a	nd/or invest	igation, in my op	inion, death o	ccurred at	the ti me , <mark>date</mark> an	d place, and	d due to the c	ause(s) and ma
	only one) 3 L Certifying N 29b. Signature and title of certifier	lurse Practitioner: To	the best of my	knowledge,		at the time, da	ite and plac			ind manner as gned (Month)	
Σ	. () ()	1				100	-				
M	30. Name and address of person wh				rint) N . U	5830	25	1.	1666	nser	17 20

11-09197 Michael W. Clark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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-	\sim	- 8	- 0	6	\sim	Street, or other Designation of the last o	_

		1- For State Registrar		Cert	ificate of	Death_					eg. No.			
Physici Medical Exami		Decedent's Name (First, Middle	Michael W. Clark December 6, 2011 Year 2116							Time of Death 2116 hrs				
		4a. Facility Name (if not institution 13 Riverside Road	nstitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Essex Baltimore County								ty .			
Funeral Director		5. Social Security Number 219-84-1243	6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/II 1 M 2 F 46 Yrs. 1 Months Days Hours Min. Dec. 20, 1								F-	oreign	olace (State or try) MT)	
	-	Usual Residence of Decedent	1 XM 2 F	46	Yrs.					рес.	20,19	04]		// EID
v any		10a. State 10b. County		10c. City, T	own or Locatio	n								Od. Inside City Limits Yes 2 No
Aaryland 28a-f show 1 at once.	for		imore			105 7:- 0-		Essex	ζ		0g. Citizen	of Mhat		
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 13 Riverside	Road			10f. Zip Co 212				- 1	-	ted		
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f shr ent, the Medical Examiner must he notified at once		11. Marital Status	12. Was Deced			Decedent of s, specify C				cify Yes or No	14.	Race - A		n Indian, Black,
er deatl	Funeral	1 Never Married 2 Ma 3 Widowed 4 X Divo	1 Yes	2 X No		Yes 2X					Soe	ecify:		TT- 2 to -
ours aft tural?	d by	15. Decedent's Education (Spec	or Dates:	completed)	16a. Decedent	s Usual Occ	upatio	n (Give kin			16b. Kind			White ustry
11215-0036 Id be filed within 72 hou dental Hygiene. narked other than "natevent, the Medical Exa	pleted	Elementary/Secondary (0-12)	College (1-4	· ·	auring mo Bridge	st of working					Ma	inte	nan	ce
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Edward J. C.	lark, III							J. Ber				
Baltimore, MD 21215- permit. Pages I and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked of injury or other traumatic event, the	٩	19a Informant's Name/Relationsh Mrs. Rose Leac		n Law)	19b. Mailing 3523					ral Route Nur Dund				
Ce, M l and 2 Health item 2		20a. Method of Disposition		20b. Pl	Lace of Dispositematory or other		of ceme	etery,	[Date	20c. Loca	ation - Ci	ty or To	wn, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 X Burial 2 Cremation 4 Donation 5 Other Sp		1 State	Lawn (ery		12/1	0/2011	Ba1	timo	re,	Maryland
Balti ermit. Departn mports njury e		21. Signature of Funeral Service	Licensee		22. Na	ame and Add	dress o	of Facility						.c.222
Physician	\dashv	23a. Part I. Enter the disease, or	complications that caus	sed the death. [70 Do not enter th	22 Wine mode of d	se ying, s	Ave uch as care	Dung diac or r	da1k espiratory an	Mary 1 est, shock,	and or heart	21	Approximate Interval
Wedical xaminer	į.	failure. List only one cause Immediate Cause (Final disease	on each line.											Between Onset and Death
Adminion		or condition resulting in death)	Due to (or as a co	onsequence of):										
	miner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onse uence of										
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ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - trans	ü	27. Manner of Death 1 X Natural 5 Pend	28a. Date of (Month, Date)	Injury ay,Year)	28b. Time of In	· ·		at Work? es 2 ☐ N	- 1	8d. Describe	how injury (occurred		
24a. Was an autopsy performed? 1								Route Number, City						
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C		nysician: To the best o											
To To To Com	Med	29b. Signature and title of certifie	and manner state	ed.		29c. Li	cense	number			29d, Date	e signed	(Month	n, Day, Year)
		1/2		ny		C	.C.N	1.E.			Decen	nber 7,	2011	
\mathcal{A}		30. Name and address of person Russell Alexander MD				V. Baltim	ore S	Street. B	altimo	re, MD 21	223			
<u>\$</u>	tate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	e _a						_			
Regis	trar	DEC 16	6011 Cen	was fo	7. BU	Kel				001	VE.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12/2011 Physician/ Mary Ellen Crockett 2:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Halethorpe 3707 Century Avenue If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Hours Min 12/4/1938 Virginia 1 □ M 2 💢 F 218-34-2962 73 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Halethorpe Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 USA 3707 Century Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ξ If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic month. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) စ Mary M. Hudson Robert E. Lee 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3707 Century Avenue, Halethorpe, Maryland 21227 Evelyn M. Schultz / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Cedar Hill Cemetery | 12/15/2011 Brooklyn Park, MD Signature of Funeral Service Dicensee 22. Name and Address of Facility Hubbard FUneral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying ysician and e burial-transit Exami Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has performed To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 270 No ၣ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral filled in by the funeral completed filled in by the funeral completed filled in by the funeral 5 Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syll Did Frederick Rd - Suite IS

Bultimed Mul 2 1239

32. Regist

31. Date filed (Month, Day, Year)

6 2011

038762

Sharon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ ohy D 6:55 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 X M 2 D F Months Days Hours Min 725-07-5814 Yrs Director 83 11/1/1928 N.C. Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director N/A Baltimore MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code r items 23a or ner must be n ö 10g. Citizen of What Country? Funeral 21218 USA 3900 Loch Raven Blvd. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: "natural", 3 Wildowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Seaboard RailRoad and Mental Hygie is marked other 10th Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Deloatch Annie Barnes and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sandra Riddish - Niece 411 Denton St. Durham, South Carolina 27701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Donation 5 Cher (Specify) Garrison Vet. Cemt. 12/20/2011 Owings Mills, MD 21. Sunature of Funeral Service Licenses 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD 21202 art . Enter the disease, or complications that causeus sho k, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the dear Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death Imr edi le Cause (Final disease or condition Physician/ disease or conunctive resulting in death) mentia Medical Due to or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy j in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death the detached a | Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe certificate | 1 ☐ Yes 2 ☐ No 2 Z N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending work? 1 Matural injury 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within 2 29b. Signature and tible of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2+14 axl 31. Date filed (Month, Day, Year, 32. Registrar's

DHMH 17 Rev 7/2009

State Registrar

5-0036 Jygene Thours after death with Typene The Watural's ur items 23 the Medical Examiner must be no Commisted by Ermores!	1- For State Registrar 1. Decedent 1. Decedent 4a. Facility N 1409 G 5. Social Sec 220 – 82 Usual Reside 10a. State MD 10e. Street a 1409 11. Marital Si 1 Never 3 Widov 15. Decede Elementan 17. Father's R Benj 19a. Informar Jenita 20a. Method	s Name (First, Midde amin Wood ame (if not institution is such a	ds Dickens, on, give street and number of the street and number of the street and number of the street arried arri	Der) Age (In yrs. 49 10c. City	last birthday) Yr 7, Town or Loca Baltimo	4b. City, Town, Baltimore If Under 1 Y Months D tion 10f. Zip Code 212. as Decedent of It fes, specify Cub Yes 2 X N nt's Usual Occup lost of working li	or Location of De ear If Under 24 ays Hours I Hispanic Origin? (an, Mexican, Pue	2. Date of De Month Decemberath Hrs. 8. Date of Berlin (1987) Specify Yes or Norto Rican, etc.)	4c. County of De 4c. County of De iirth (MM/DD/YYYY) 9. If 5/1962 Tog. Citizen of What County of De U.S.A. 14. Race - Am White, etc.	3. Time of Death 1409 hrs ath Birthplace (State or eign Country) MD 10d. Inside City Limits 1 X Yes 2 No Nountry? erican Indian, Black,	
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Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or nither tr	4 Donati		n 3 Removal from	State	crematory or ot dent Cr	her place) emation	12	/15/11	Hanover,	Maryland	
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Part II. Other significant conditions End stage renal disease 23e. Did tobacco use contribute 1								s 2 No 3 Pro	obably 4 Unknown		
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Division of spital or Attending Pt hours after death. oeral Director: After trilled in by the funeral Certification: T	1 Natura 2 Accide	nt Invest	FOUND: Day tigation Dec 12, 201	y,Year) 11	FOUND: 1905 hrs	1	Yes 2 V No	erosion of d	ialysis graft in left		
3 Suicide 6 Could not be determined (Specify) Multi-Family Apt. 28e. Place of Injury - At home, farm, street, factor (Specify) Multi-Family Apt. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.							or Town, State) 1409 Gough Street, Baltimore, MD				
To the Hos within 24 h The Fue completely	(Check only one) 2	✓ Medical Exam	ysician: To the best or niner:On the basis of ex and manner stated	camination ar	_{je} , ueath occurr nd/or investigati	ed at the time, o on, in my opinio	iate and place, ar n, death occurred	at the time, date	e(s) and manner as sta and place, and due to the	ted. ne cause(s)	
₽ 3 A 8 P	29b. Signature	and title of certifier		<u>u. </u>		29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)	
	10-1)				O.C.	.M.E.		December 13, 2	011	
		address of person v	who completed cause of Assistant Med		,	A/ Baltima-	Street Date	more MD 04	222		
State	31. Date filed (r's Signatu	_	v. pailimore	s Sueet, Balti	more, MD 21			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dixon Gloria Ann 12:01 AM December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Health and Rehabilitation Center artord If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) eb. 17,1936 1 M 2 X F Days Months Hours Mary land 212-36-8268 Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Harford Joppa MD 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 611 Stans Road 21085 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 XNo Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Years Pharmacist Technician Pharmaceutical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma E. Fisher Joseph F. Connell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Stans Road Joppa, Maryland 21085 James H. Dixon, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from 12/13/2011 4 Domation Oak Lawn Cemetery Baltimore, Maryland 5 Other (Specify) 21. Signature ineral S 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise/Ave. Dundalk, Maryland Inc. 21222 23a. Part 1. Enter the disease, or complications that cars shock, or heart failure. List only one cause on each l ter the mode of dying such asycardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) Month the a 1 ☐ Yes 2 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has b 24a. Was an performed this certificate 1 Yes I director, of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending work? Division 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical Certifying Physicians. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 01 31 Date filed (Month, Day, State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:40 P M Audrey Daniels December 10 2011 D. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Montgomery Rockville Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Director 577-62-1544 1 🗆 M 2 🗓 F 86 02/04/1925 England, UK Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC Washington D.C. XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4100 Cathedral Ave. NW United Kingdom 20016 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Force Black, White, etc ed other than "natural", or i event, the Medical Examin 1 ☐ Yes 2X No If Yes, Give Completed by 1 X Never Married 2 Married 72 hours after 1 Yes 2X No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Administrative Officer Inter-Governmental Org Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanley William Daniels Alice Elizabeth Halls 19a. Informant's Name/Relationship (Type, Print) Attorney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. Stephanie Grogan / in Fact 5907 Massachusetts Ave., Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory 12/13/2011 4 Donation 5 Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral and Cremation Services Gist Ave., Silver Spring, MD ~ 41 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

√
Sta

21215-0036

Baltimore, Maryland

Box 68760

P.O.

Records.

Division of Vital

State Registrar 31. Date filed (Month, Day, Year) TFC 1 6 201

29b. Signature and title of certifier

SANDEEP SHARMA M.D., 743 SUMMER WALK DR., GAITHERSBURG, MD. Date filed (Month, Day, Year) 3. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D64624

29d. Date signed (Month, Day, Year)

DECEMBER 13, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 1215A ECENT 20 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Raltimore Catonsville Frederick Villa Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Hours (Month, Day, Year) 02/08/1924 1 M 2 XF Maryland 216-18-6008 87 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No Baltimore Edmondson Heights Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21207 1612 Kirkwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3XXWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname)

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 Physician/ Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

þ

Completed

Examiner

Funeral

Director

28a-f show

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours after deat To the Funeral Director:

the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

To Be	17. Father's Name (First, Middle, Last) Cornelius Busch	18. Mother's Name (First, Middle, Maiden Sumame) Clara Funk						
		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	Michael DelCavio - Son 1612	Kirkwood Road Baltimore, Maryland 21207						
h i	20a. Method of Disposition 20b. Place of Dispo	osition (Name of Date 20c. Location - City or Town, State matory or other place)						
	T Dunai 242 Oremation 3 Li hemovariioni state	Crematory 12/19/2011 Glen Burnie, Maryland						
	21. Signature of Funer Larvice Licensee	avid J. Weber Funeral Homes P.A. 311 Edmondson Avenue Baltimore, Maryland 21229						
	23a. Part 7. Enter the disease, or complications that caused the death. Do not ent	er the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between						
ga is	Immediate Cause (Final disease or condition	Onset and Death						
	resulting in death) Due to (or as a consequence of):							
7	Sequentially list conditions, b.							
mine	If a m, leading to immediate cause. Enter Underlying Cause (Disease or injury)							
Exal	that initiated events resulting in death) Last C. Due to (or as a consequence of):							
cal								
edi	d							
Μ'	IF FEMALE: 23b. Was decedent pregnanty 23c. If yes, outcome of pregnancy	23d. Date of delivery						
ciar	in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month Day Year							
hysi	9 Unknown							
y P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?						
Completed by Physician/Medical Examiner	S/F CVT	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hiknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?						
plet	chranic Af	n'al h'6 n'lbh' n 24a. Was an autopsy prior to completion of cause of						
Corr		performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No						
Be	25. Was case referred to medical	26. Place of Death (Check only one)						
2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
ate:	27. Manner of Death 28a. Date of injury 28b. Time of (Month, Day, Year) injury	f 28c. Injury at work? 28d. Describe how injury occurred						
2 Accident Investigation M 1 Yes 2 No								
Cert	4 Homicide determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Medical Certificate: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investonly one) 3 Certifying Nurse Practioner: To the best of my knowledge,	occured at the time, date and place, and due to the cause(s) and manner as stated. stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature Potitle of certifier Aff	29c. License number 29d. Date signed (Month, Day, Year)						
	My My	D36542 December 14, 2011						
	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)						
	B. TURAICHIA, MD 100%	Geleick Rd. Cofenyalle, Mo 2122.						

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3CTM Physician/ C Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Season's Hospice Randallstown Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under **Funeral** Min. (Month, Day, Year) Director 218-36-8605 71 1 M 2 X F Yrs 10 22 40 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or no any injury or other traumatic event. The Machine Conce. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Randallstown MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 9719 Mendoza Road 21133 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3X☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12th grade Office Administrator Crown Cork and Seal lyr Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Velma Rosalee Fletcher Buster Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9719 Mendoza Road, Randallstown, Md 21133 Michael Savage-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ⊠ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Garrison Forest 12/28/2011 Owings Mills, Md Donation 5 Other (Specify) of Funeral Service Licensee Signate Name and Address of Facility Warch F/H West 4300 Wabash Ave, 21215 Baltimore, Md Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final ey moniA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò should be 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform page 2 24 hours after death.

Funeral Director: After this certificate Yes 2 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Machinian Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 3 only one

State Registrar 29b. Signature and title of

30. Name and address of person w

1 6 2011

31. Date filed (Month, Day, Year)

tion Blud alen

e of death (Item 23a) (Type, Print)

6934

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elias Pau1 5:00 A M December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1024 Copley Lane Silver Spring Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Director 577-44-4570 1**X** M 2 □ F New York 77 03/21/1934 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 United States 1024 Copley Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1X Yes If Yes, Give by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Divorced 4 Divorced White Year or Dates. 1953-76 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Army Officer Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elias Pau1 Marion Frey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances B. Elias / Wife 1024 Copley Lane, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/14/2011 Beltsville, MD 21. Signature of Funeral Service 401539 22. Name and Address of Facility Kapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) AORTIC ANEURYSUM Medical Due to (or as a consequence of) **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, Due to (or as a consequence of thany, leading to immedicause. Enter Underlying Cause (Disease or injury Exami death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 \square Yes 2 $\frac{1}{X}$ No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? or Attending Physician: The after death. 1 Yes 2 No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner's Hospital Other: ည 1 🗌 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death. neral Director: After th y filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral D 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and/or investigation, in tity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 13, 2011 D18813 16x1 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) IRA TAUBER M.D., 10301 GEORGIA AVE. #304, SILVER SPRING, MD 20902 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 02:52 A.M Freisheim Bertye Elmira December 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Co. Gilchrist Center Howard County Columbia If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral Director** 212-40-0892 1 □ M 2 🗶 F 98 Maryland 03/09/1913 Usual Residence of Deceden 10d. Inside City Limits 28a-f shov at 10a. State 10b. County 10c. City. Town or Location Director ms 23a or 28a-f s must be notified 1 Yes 2X No MD Howard Co. Columbia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6308 Sun High Place 21045 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner ō 1 Never Married 2 Married þ ☐Yes 2XXXNo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify ed other than "natural", event, the Medical Exa 3 ▼ Widowed 4 □ Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Should be filed with h and Mental Hygien. T is marked other th Healthcare Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev. ပ Huffman Harriett Ann Alfred Fryfogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21045 Mrs. Harriett A. Totten/Daughter 6308 Sun High Place Columbia, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/15/2011 Randallstown, MD Olive Cemetery 22. Name and Address of Facility Singleton Funeral & Cremation M01121 1 2nd Ave SW: Glen Burnie Services PA: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List one cause on each line. Approximate Interval Between Onset and Death COMPLICATIONS OF DEMENTIA Immediate Cause (Final Ph_sician/ YEARS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Iding physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 1 Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 X No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 3 🗍 only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State

Registrar

DANIEUE DOBERMAN, ILD 6336

31. Date filed (Month Dev. *Year) 32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IFC 1 6 2011 A Santar A Santar

D64395

CEDAR LANE

DECEMBER 13, 2011

COLUMBIA, NO 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Flamer Chase 2011 6:58 P^{M} Margaret December Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Care, Inc. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min Days 218-50-0890 Director 1 □ M 2 XX 7/2/1949 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location Director 1 Yes 2XXNo MD Anne Arundel Glen Burnie 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 USA 372 Cork Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2XXNo Black, White, etc. 0 by 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2XX No Specify: **Black** "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 6 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filer Department of Health and Mental Hi Important: If item 27 is marked off any injury or other traumatic even once. Missouri Hi11 Chase, Sr. Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21060 372 Cork Road Mr. Walter Flamer / Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 12/17/2011 Glen Burnie, MD 21. Signatur 22. Name and Address of Facility Singleton Funeral & Cremation Euneral Service Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between shock, or heart failure, Li Onset and Death Immediate Cause (Final Ph_sician/ recorras disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Secuentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of D ath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🚅 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur

State Registrar 31. Date filed (Month

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40248 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 13 2011 1:20 P M December Mary Lou Fesmire Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 12240 Roundwood Road #801 Timonium . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min. March 1 Year 927 Mary Land 214-22-6681 84 **Director** 1 🗆 M 2 🗶 F Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at Director 28a-f 1 Yes 2 X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21093 U.S.A. 12240 Roundwood Road #801 death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed f Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mary Amelia James Paul Cahill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11123 Lynn Drive, Kingsville, Maryland 21087 Christa Payne / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State o = 10 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or DulaneyValleyMem.Gdns: 12/16/2011 |Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Full and Service Lines 1050 York Road Towson, Maryland ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. Part 1. Enter the disease, or comple shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) ~012 cancel Medical Due to (or as a consequence of) **Examiner** bower 0927 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Exami Due to (or as a consequence of) Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last ttending physician and for use as the burial-tran Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy performe death? 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending s after death. Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor **To the Fune** completely fi 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 12/14/11 3747271 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9

Registrar DHMH 17 Rev 06-2011

State

Daniel Collector, MD

31. Date filed (Month Day, Year)

1734 York Road, Lutherville, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 05:30 AM December 9,2011 16ming /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number), 4b. City, Town, or Location of Death **Examiner** LORIEN Be1 Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 24,1915 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Country) Virginia Months 1 □ M 2 😡 F Oct. Yrs. **Director** 96 230-34-8329 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Experient must be notified at 1 Yes 2 No Director Perry Hall MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21128 United States 9503-D Kingscroft Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 📉 No ģ Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Steelworker 7 Years other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental marked Grace Kelly Teamous Phipps 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health an 9503-D Kingscroft Terrace Perry Hall, MD 21128 Mr. Robert D. Fleming (Son) permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₹XBurial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland 4 Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 12/12/2011 22. Name and Address of Facility
Luda-Ruck Funeral Home of Dundalk, 21. Signatur of Funeral Service Licenses 12 21222 7922 Ave. Dundalk, Maryland Wise Part I. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (r as a consequence of) **Examiner** Kero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events resulting in death) Last (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical cate has been signed by the attending | page 2 should be detached for use as IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital; Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation after death. death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending Physician: 24 hours completely To the within 2

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause MD



and manner stated.

29c. License number

(0)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month EDA Physician/ 2010M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Feb 11, Director 1 M 2 F 1934 West Virginia 381-38-9151 77 Usual Residence of Deceden 28a-f shov death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 □ No Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2157 Whistler Avenue 21230 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White "natural", Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Factory Worker Factory 12 should be filed with and Mental Hygie
27 is marked other raumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Edgar Wells Juanita Virginia Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 st of Health a If item 27 is Theresa M. Romm/daughter 510 Cross Creek Ct. Chester, MD 21619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department c Important: If any injury or c 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/16/11 Woodbine, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final ROKE Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions Examine Dise to for as a number where of cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director, After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မြ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a 29a. Certifier 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

Name and address of person who

31. Date filed (Month, Day, Year)

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use of death (Item 23a) (Type, Print)

Registrar's Si

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40251 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Robert Felsecker December 6:45 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens Assisted Living Montgomery Silver Spring, | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 21,1919 **Funeral** . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 Wisconsin Director 314-05-6185 92 Sept. Usual Residence of Decedent 28a-f show ntal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Silver Spring 1 🗆 Yes 2 🖁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 3160 Gracefield Rd. OG-3143 20904 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 XWidowed 4 Divorced Year or DatesW. II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Washington Gas Comp. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other tl Radio Technician Utilities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 9 Felsecker Elizabeth Harmever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is Julia K. Theodore / Daughter 5705 Bideford Ct., Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Chesapeake Crematory ! 12/15/2011 Beltsville, MD Mol539 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician disease or condition Medical resulting in death) Due to (or as a ons guence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Je 2 r this certificate has eral director, page 2 performe 1 Yes 2 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No ပ္ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Dea h Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death.

I Director: Aft
d in by the fur 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi Certifying Nurse Practioner: Tu the best of my knowledge, chath occurred at the flure, date and place, and due to the cause(s) and marker as state. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 112633 30. Name and address of person who completed cause of death (Item 23a (Type, Print)

Registrar

JULIANE HARDING RNP

31. Date file (Month, Day

3110 GRACEFIELD RD., SILVER SPIRNG, MD

20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 2925 3-12-12 yt State of Maryland /Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14, 20¹1 Virginia Davis Lock Fisher 9:20 P December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Friends Nursing Home Sandy Spring Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 4, 1918 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🗓 F Months Hours ennsylvania Director 220-34-3337 93 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Bethesda Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 4514 Chestnut Street United States 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No. Specify 3 😾 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed wto. Hat Hygiene. Sor than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with hand Mental Hygien 7 is marked other th Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Guy LeRoy Davis Florence Marie Nally 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 4508 Cheltenham Drive, Bethesda, Maryland 20814 Virginia Lock Baran/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of unk. Date 20c. Location - City or Town, State Arlington National
Cemetery crematory or other place
Arlington National 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2-17-12 Arlington, Virginia Pumphrey Funeral Home/ c. 7557 Wisconsin Avenue 22. Name and Address of Facilit Robert A. P Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee M01498 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ End Stage Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Failure to Thrive Examine Due to (or as a consequence of) sician and burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? uns certificate has b il director, page 2 sh 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide nours after death nera! Director: A I filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined n 24 hours a Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as etaled. (Check To the within 2 To the P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 15, 2011 D35791 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Merlyn Vemury, MD 9801 Georgia Avenue, #227, Silver Spring, Maryland 20902 Merlyn Vemury, MD 31. Date filed (Month, Day, Year, State DEC 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12,2011 Physician/ Month DECEMBER KLEIN 7:50A JOSEPHINE FELDMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, You Jan. 28, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** ^{Year)}1912 Days Hours 1 M 2 V 99 Jän. 493-05-0640 Missouri Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or the fraumatical may injury or other tra 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 High Acre Drive 21157 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jacob Μ. Klein Gussie Herschkowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Sitzer/Daughter 7721 Country Club Ct., St. Louis, Missouri 63105 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/14/2011 | Baltimore, Maryland Metro Crematory Inc. 22. Name and Address of FacilityCremation Society of Maryland Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician MYO CAROLAL INFANCTION disease or condition resulting in death) Medica Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to or as a conse uence of that initiated events resulting in death) Last Due to (or as a consequence of) ding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed' Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Medical Certificate: To 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a, Certifier 🕻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat 47951

DHMH 17 Rev 7/2009

State

Registrar

814

TOIL

HOUSE ALE,

ne and address of person who completed cause of death (Item 23a) (Type, Print)

KAZMI

31. Date filed (Month, Day, Year)

6

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32. Registrar's Signatur

1-09264 tichael Francis	Cic	Please Type or I							gible.		
iichael Francis	GIS	1- For State	Maryland /		ent of Hea ate of Dea		d Mental H		g. No.	01	1 4025
Physici ledical Exam		Registrar 1. Decedent's Name (First, Middle,Last) Michael Francis Gis						2. Date of Deat Month	h Day Y	ear	3. Time of Death 0523 hrs
nedical Exam	iiic.	4a. Facility Name (if not institution, give str 922 Rock Spring Road			4b. City Bel		Location of Deat	December	4c. Count Harford		
Funeral Director		5. Social Security Number 6. Sex 219–25–6013	7. Age	(In yrs. last bir	thday) If Ur Mon Yrs.	nder 1 Yea		_	16,1988		thplace (State or Scranton, PA untry)
Aaryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Harford C		Oc. City, Town	ettsvill						10d. Inside City Limits 1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 3543 Anderson Lane			101. 2	ip Code	21084	1"	og. Citizen of V Uni t		states
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	/ Funeral	1 K Never Married 2 Married 1	es, Give Yaar	ver in U.S.	If Yes, spe	cify Cubar	spanic Origin? (S n, Mexican, Puerto specify:			ite, etc.	can Indian, Black, Thite
2 hours a "natural	eted by	15. Decedent's Education (Specify only h	Dates: ighest grade comp College (1-4 or 5+				tion (Give kind of . DO NOT use ret		16b. Kind of I	Business/I	ndustry
215-0036 be filed within 7. ntal Hygiene. rked other than ent, the Medical	Completed	12 17. Father's Name (First, Middle, Last)	N/A		Pl		Worker 18.Mother's Name	o (Eiret Middle N			& Company
11215-0036 d be filed within 72 ho fental Hygiene. arked other than "na event, the Medical Ex	Be	Francis Wayne Gist					Karen L	etschin			
MD 21 d 2 should Ith and Mei n 27 is man	7	19a. Informant's Name/Relationship (Type, Mr. & Mrs.Francis W.	,				et and Number or son Lane				Zip Code) 21084
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other Specify:		Evans F	ന യോഗ്	apel a	nd Thu	Date 1750by , 15,2011	Forest	Hil	d County) 1,Maryland
Balt permit Depart Impor		21. Signature of Funeral Service Licensee	Lic	:.#M00677	2325	ul Ali York I	s of Facility Ternal Tives Road Ti	Funeral a	nd Creme yland	tion (21093	Center, P.A. -2215
Physician Medical	100	234. Part I Enter the disease, or complicate failure. List only one cause on each li		e death. Do no	ot enter the mode	e of dying,	such as cardiac o	or respiratory arre	est, shock, or h	eart	Approximate Interval Between Onset and Death
≟xaminer		100 NO 1 1 1 1 1 1	to (or as a conseq	uence of):							
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	to (or as a conseq	uence of):							
xecuted and transit	Ä	(Disease or injury that initiated	to (or as a conseq	uence of):							
ੂਲ ਜ਼ਿਲ੍ਹ	dical		MENDED								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burnal	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome Live birth Pregnant at tir		Fetal deat		Ectopic pregna	ancy	23d. Date Month		day Year
ires that the disigned by the	by P		stributing to death b	out not resulting	g in the underlying	ng cause g	given in Part I.				the cause of death?
Records, The law require ficate has been si	Completed							24a. Was a	sy	prior to c	topsy findings available ompletion of cause of
tal Rec		25. Was case referred to medical				26 Place	of Death (Check	perfor 1 ✓ Yes 2		death? 1 ✓ Ye	s 2 No
Vital ysician his cert directo	o Be	examiner? 1 ✓ Yes 2 No	ital: 1 Inpatient	2 ER/0	utpatient 3	DOA DOA	Other -		Residence 6	✓ Other	: Scene
on of ading Ph. th. : After the funeral	ion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury FOUND: Day, Yea	r) FOU			ry at Work? Yes 2 ✔ No	28d. Describe h Struck by me			
ivisical or Atter after dea	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	Dec 9, 2011 28e. Place of Injur	y - At home, fa				or Town, S	tate)		ral Route Number, City
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:		29a. Certifier (Check only 1 Certifying Physician:	_	knowledge, dea	ath occurred at the				e(s) and mann	er as state	ed.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On and 29b. Signature and title of certifier	the basis of exami	nation and/or li		ny opinion 9c. Licens		at the time, date a			e cause(s) nth, Day, Year)
		Carol H	Al Qu	da		O.C.I	M.E.		Decembe	r 9, 201	1
1.9		1934 W 50V 11	Medical Exami	ner 900 V			Baltimore, M	D 21223			
St	ate	31. Date filed (Month, Day, Year)	32. Fegistrar s	Signature	back	1					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 2011 5:05 Gottesfeld Sheldon 5 4 1 Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 8. Date of Birth (Month Day, Jan 18, 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 **X** M 2 □ F Months New York 59 Director 148-40-0668 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director Jarrettsville 1 Yes 2 No MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21084 3532 Glen Oak Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Specify: White 3altimore, Maryland 21215-0036 1 Yes 2X No Specify. 30Hes Peld, Sheldon Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner-Recruiting Firm Consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anderman Rella Gottesfeld Sal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3532 Glen Oak Dr., Jarrettsville, MD 21084 19a. Informant's Name/Relationship (Type, Print) Teresa Gottesfeld - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State Hilltop Serv Corp Towson, MD 12/16/11 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee William 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) ☐ Live Birth 2 ☐ Fetal deat☐ Pregnant at time of death☐ Unknown Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 2 No 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ER/Outpatient 3 DOA မ 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 - Natural 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Montil, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar amend 5-22 per ab g930 8/3/12 erkincate of Death Reg. No. 2011-40256 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAYANK Physician/ 11:10 A NOVEMBER 01,2011 Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (if not institution, give street and number Examiner MON TGOMERY SHABY GROVE ADVENTUT HESPITAL COCKVILLE 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) Social Security Number **Funeral** Min 1 X M 2 D F **Director** Maryland 1 32 11/1/11 or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland at Director be notified Germantown 1 Yes 2 No MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 23a 20874 with 20806 Gaelic Court must h death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Marital Status Black, White, etc. Never Married 2 Married by 'natural", or 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after Specify: Indian Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Nidowed 4 Divorced r than "nature the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) fe. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Infant 0 Infant Be 18. Mother's Name (First, Middle, Maiden Surname) **Preethibhargavi Gudi** 17. Father's Name (First, Middle, Last) Ramachandra Aravind Batni ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).
9901 Medical Center Dr. Rockville, Md. 20850 19a. Informant's Name/Relationship (Type, Print) Shady Grove Adventist Hosp. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4x Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St. 21201 Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final PREMATURITY Ph. ician/ EXTREME disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) n 24 hours atter מבשביה... he Funeral Director: After th בוזיסוט filled in by the funera Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred iniury 1 Natural 5 Pending Investigation Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29c. License numbe 1)30660 ss of person who completed cause of death (Item 23a) (Type, Print) KEY WEST AVENUE #415, ROCKVILLE, MARYLAND MD Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12:21 P M 2011 Lyle John Garitty Jr. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Yea Dec. 29, If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1**℃** M 2 □ F 1927 Louisiana Director 439-22-2036 83 Dec. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Harford Joppa 10f. Zip Code Citizen of What Country? USA 'natural", or items 23a Funeral 304 Haverhill Road 21085 IId be filed within 72 hours after death with Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. the Medical Examiner 1 Never Married 2 Married þ 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lieutenant Colonel U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma Louise Duelfer Lyle John Garitty Sr. permit. Page 1 and 2 should Department of Health and M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any Injury or other tra 304 Haverhill Road, Joppa, Maryland 21085 <u>Carol M. Garitty / Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place. 20a. Method of Disposition 20c. Location - City or Town, State Removal from State nation 5 GO Other (Specify) Arlington Nat'l Cem. 1-4-12 Arlington, Virginia Sign Sep 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter mb disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCAROML INFACTOR disease or condition resulting in death) HIS Medical Due to (or as a consequence of) Examiner ALTERY Yrs CONVAM Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 XN 2 No this certificate 1 Yes or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Tes 1 Inpatient 2 K ER/Outpatient 3 I DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No ☐ Accident Investigation within 24 hours after dear To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 133088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bernard Birnbam MD-103
B1. Date filed (Month Day Year)

OFF. 16 2017

August 32. Regisfar's Signary Bata BIVD Beicamp mo 21017 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 40258 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ĩ<u>o</u>, Virginia Μ. Gray 2011 8:55 December Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collington Assisted Living Center Prince George's Mitchellville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours **Director** 578-50-9898 1 □ M 2 🛛 F 102 July 31,1909 New York Usual Residence of Deceder 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Mitchellville MD Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20721 United States 10450 Lottsford Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 12 should be filed within 72 hours alth and Mental Hygiene.
n 27 is marked other than "natural", or by 1 Never Married 2 Married Yes 2 XNo within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Specify. 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Non-Profit Executive Secretary 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mendenhall Franklin Phillips Annie Myrtle Dawson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or are 316 South Main Ave., Albany, NY 12208-2315 Charlotte O. Gray / Daughter Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/12/2011 Beltsville, MD 21. Signature of Funeral Carvice Livensee 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 M00382 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ week Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as 1 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 👿 No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Alzheimer's Dementia peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2X No has page 2 1 Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation filled in by the Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12/12/2011 D25079

Registrar
DHMH 17 Rev 06-2011

State

8116 Good Luck Rd., Lanham, MD

20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Don H. Yablonowitz M.D.,

31. Date filed (Month, Day, Year)

		Please Type or Print in Blac State of Maryland / D	epartment of Health		ene coll loof
Physicia Medic		Registrar 1. Decedent's Name (First, Middle, Last) Frank A. Hendriksen	Certificate of Death	2. Date of Death Dec.	13, 2011 4025. 13, 2011 5:50 M
Examin		4a. Facility Name (if not institution, give street and number) Oak Crest Care Center	4b. City, Town, or Location Parkvill		4c. County of Death Baltimore
Funeral Director			day) If Under 1 Year If Under 1 Year Months Days Hours	8. Date of Birth Min. (Month, Day, Young & 9,	9. Birthplace (State or Foreign Country) 1916 Michigan
Maryland 28a-f show otified at	Director	Usual Residence of Decedent 10a. State	or Location arkville		10d. Inside City Limits 1 ☐ Yes 2 No
with the 23a or 3	Funeral D	8820 Walther Blvd. Apt. 2016	10f. Zip Code 21234		g. Citizen of What Country? Inited States
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ह	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates. WWII	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 Yes 2 No Specify	an, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Department of Health and Page 1 and	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during mos ife. DO NOT use retired) ATF	st of working	Sb. Kind of Business Industry ederal Government
yland yland yland be filed wental Hygarked otheatic event,	To Be	17. Father's Name (First, Middle, Last) Anton Hendriksen		her's Name (First, Middle, Ma ornelia Rie	
Mary d 2 should alth and alth and 27 is mer traums			Mailing Address (Street and Numb B20 Walther B		ity or Town, State, Zip Code) 016 Parkville, MD 21234
imore, Page 1 an ment of He ant: If iter ury or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Disposition (Name of crematory or other place)		oc. Location - City or Town, State Parkville, Maryland
Balt permit. Depart Import any inj		21. Signature of Funeral Service Licensee	Evalis Funeral Char 8800 Harford Road	El & Cremation S Parkville, Mary	Services Land 21234
Ph. sician/Medical Examiner Special and a phrial-transit	ical Examiner	29 P rt 1. Enter the disease, or complications that caused the death. Do not sock, or heart failure. List only one cause on each line. I me flate Cause (Final algorithm) in the complete of the complete of the cause of the cause of the cause of the cause (Final algorithm) in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause) Due to (or as a consequence of the cause). Due to (or as a consequence of the cause) Due to (or as a consequence of the cause).	on priman		Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ords, P.O. Box	ed by Pl	Part II. Other significant conditions contributing to death but not resulting in Concessive Cardiomyoputh	the underlying cause given in Part		cco use contribute to the cause of death?
Vital Recorc ysician: The law req is certificate has bee director, page 2 shou		hypoxenia deleium 25. Was case referred to medical	OS Place of Day	24a. Was an autopsy performe 1 Yes 2 (ath (Check only one)	24b. Were autopsy findings available prior to completion of cause of death? 1
f Vita Physicia this cert ral direct	: To Be	examiner? 1	patient 3 DOA Other: 4 N	lursing Home 5 - Residence	
Division of V Houspital or Attending Phys 24 hours after death. Funeral Director: After this eted filled in by the funeral di	Certificate:		work? M 1 Yes 2		et and Number or Rural Route Number,
Ospital o hours af hours af uneral Di ad filled in	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occured at the time, date and	place, and due to the cause	s) and manner as stated
Division To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the		(Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier	dge, death occurred at the time, date 29c. License number	e and place, and due to the ca	place, and due to the cause(s) and manner stated. use(s) and manner as stated. Date signed (Month, Day, Year)
O _a xi		30. Name and ddress of person who completed cause of death (Hem 23a) (Ty	DOD 309 7	72	2/15/11
T) '			ark ville mI) Kaven	K. Ging Mi)
Registra	-	DEC 1 6 2011 June 1	parle		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ wendolyn Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Sauate Rosedal Baltimore HOSPITa 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 Months Days Hours Min. 213-36-0950 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location the Maryland Director "natural", or items 23a or 28a-f sidical Examiner must be notified なっていか 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral I and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.

'is marked other than "natul raumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jaene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is harles Maryland street injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Miltimore 4 ☐ Donation 5 ☐ Other (Specify) 2011 Chapel and Cremation Services Signature of Funeral Service Licenses 22. Name and Address of Facility
Eugens Function
8800 Harford Road Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Endocarditis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner abscess ocardial Sequentially list conditions. Examine cause. Enter Underlying o lor as a consequence of Sta the Hospital or Attending Physician: The law requires that the death certificate be executed taphylococcal
Due to for as a donsequence of): S Cause (Disease or linjury burial-tran that initiated events physician Completed by Physician/Medical Fadure enal Division of Vital Records, P.O. Box 68760 the for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 24a. Was an cate has autopsy certificate director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural iniury 5 Pending Accident Investigation after death Director, 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed f (Check only one)

Registrar

29b. Signature and title of certifier

DR Danna

31. Date filed (Month, Day, Y

Tanna

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ota

Dorat

16

DHMH 17 Rev 7/2009

State

ORIGINAL

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 2 No

Day

3. Time of Death

925

10d. Inside City Limits

Manylanc

Approximate Interval Between Onset and Death

MD 21234

1 Yes 2 No

9. Birthplace (State or Foreign

Country)

White

2011

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

29c. License number 29d, Date signed (Month, Day, Year)

9000 FRANKLIN Square DR

201

21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 20 Marvann T. Holcomb-Dziennik Dec. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 607 Almond Avenue Essex 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs. last birthday, **Funeral** Country Days Hours April 126, 1947 218-46-7502 Director 64 Yrs. 1 M 2 X F Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c, City, Town or Location 10a. State with the Maryland Director MD Baltimore Essex 1 Yes 2 Min 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 USA Funeral 607 Almond Avenue "natural", or items 23a death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 72 and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12th College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anne White Paul Bohland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If Item 27 is any injury or other traingone. 607 Almond Ave. Balto.MD. 21221 Robert F. Dziennik /husband Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State SacredHeart of Jesus 12/17/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month for Pregnant at time of death the 2 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ VENOUS THROMBOSIS 1 Yes 2 No 3 Probably Unknown Records, Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has performed 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie DECEMBER 15. 2011

Registrar

State

10

BALTIMORE MO 21207

impleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40262 Certificate of Death 3. Time of Death 7:40 P M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month George V. Hilker 2011 December Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner are Hospita 3altimo! sedale last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 219-30-4583 Hours March 26, 1934 Country) 77 Yrs **Director** 1 **X** M 2 □ F MD 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified Baltimore MD Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 ms 23a or must be Funeral 3438 Yardly Drive 21222 USA 27 is marked other than "natural", or items raumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Vulcan-Hart Co. Sand Blaster 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward F. Hilker Marie T. Ziolkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Hilker/wife 3438 Yardly Drive Baltimore MD 21222 permit. Page 1 and 2:3 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Bayview Crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12/19/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat ve f Fu, eral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 300 MAce Ave. Balto N Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** bowe Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury use as the burlal-trar that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) the a 9 Unknown g Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe d be (Squamous cell carcinoma of oropharynx 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 15chemic cardiomyopathy, coronary aftery disease 24a. Was an autopsy performed? Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital ျှ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year)

la

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day,

9000 Frank

250000

Drive, Baltimore Mn. 21237

Square

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40263 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ DECEMBER Day 2011 FELICIA HAGER 3:20 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WASHINGTON ADVENTIST HOSPITAL PARK TAKOMA Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y AUG 24 If Under 1 Year 9. Birthplace (State or Foreign Funeral Year) 963 1 M 2 X F Days Min Months Hours MARYLAND 579-82-2521 48 Director Usual Residence of Decedent 28a-f shov 10h County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD PRINCE GEORGE'S LANDOVER 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20785 6502 WEST FOREST ROAD #201 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Force þ 1 X Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. PRIVATE CASHIER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ဂ THOMAS M. HAGER HILDA D. WATSON permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6502 WEST FOREST ROAD #201 LANDOVER, MARYLAND 20785 CYNTHIA CURTIS/NIECE 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2011 LINCOLN CEMETERY 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the diseate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ GITICEMIA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last physician and s the burial-transit that the death certificate be executed Due to (or as a consequence of Physician/Medical attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ó in the past 12 months?
1 Yes 2 XNo Month Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🔀 No 3 🗌 Probably 4 🗌 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 X No page death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiclan: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No ဂ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 2

State

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital Records,

Registrar

25A HAMOVE NYEJIAKA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARKWAY

GREGNBELT MARYLAND 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Hidalgo Fernando 6:15 A 2011 Dec. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10517 Longbranch Road Baltimore Co. Cockeysville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 220-38-4951 Hours 1 🗶 M 2 🗆 F **Director** 70 5/13/1941 Honduras Usual Residence of Deced or 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Yes 2 X No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a ed other than "natural", or items 23 event, the Medical Examiner must 10517 Longbranch Road 21030 U.S.A. . Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married hours after Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Honduran 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene.
27 is marked other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Carlos Roberto Hidalgo Marie Louisa Martinez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 Sugar Tree Place Cockeysville, MD 21030 Pamela Yvette Calwell / Dtr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 12/19/2011 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 1050 York Road Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pleural Physician/ Meson disease or condition resulting in death) month Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery jo in the past 12 months? Month Dav Year 1 Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 124 hours after death.
Funeral Director: After this certificate h performed Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 024356 Waltefeds 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William Waterfield 9103 Franklin Square Drive Suite 2200

Registrar

State

31. Date filed (Month Day, Year)

Rosedale, MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12/11/2011 Edmund C. Hommerbocker 8:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Hospice Towson Baltimore If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min. 6/20/1937 Director 216-34-5716 1 XM 2 🗆 F Maryland 74 or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2541 Christian Street 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 🗆 Widowed 4 🔀 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bus Driver School Bus Co. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Hommerbocker Mabel Morrissette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Hommerbocker, Sp 5124 Shenstone Drive, Virginia Beach, Va 23455 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 12/16/2011 Sykesville, Maryland Donation 5 Other (Specify) Lakeview Mem. Pk. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Box 68760 the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month. Dav. Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State DEC 1 6 2011 Registrar

DHMH 17 Rev 06-2011

707T

DECEMBER

MERBOCKER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 For State Registrar 40266 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 10:43 P M **Physician** William C. Hurley December ZOil /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore **Baltimore** Johns Hopkins Bayview Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**XX**M 2 □ F October | Maryland 212-01-7424 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Maryland N/A Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 4931 Sinclair Lane USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No WWII 14. Race - American Indian, Black. White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 💢 o Specify: White 9 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) General Foreman Crown Cork and Seal Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, tonce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Edward Hurley Ida Mae Robinson မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jude McNelis/ Daughter 10207 Greenside Drive Cockeysville MD 21030 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 12/16/11 Baltimore Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Inc. 5305 Harford Road Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial **Physician** /Medical Due to (or as a consequence of): Atherosclerosis Examiner Anter Coronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dub to for as a consequence of eral Director; After this certificate has Feen signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 Tes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 ☐ Yes 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 XDOA 1 Tes 6 Cher (Specify) ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: hours after death. 1 Natural 5 Pending investigation Injury 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

31. Date filed (Month, Day, Year)

DEC 1 6 2011 Registrar

Harry A. Silber, M.D., Cardiology, Suite 2400, 301 Building, 32. Registrar Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

D005 3859

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Remistrar's Signature

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar

Laron Locke MD.

31. Date filed (Month; Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40268 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician/ FRANCES FAY HOLBERG 10:56 **DECEMBER** 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CENTER 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 F Director NEBRASKA FEB 26. 1918 521-34-8048 Usual Residence of Decedent items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD HARFORD 10f. Zip Code 10g. Citizen of What Country? Funeral USA 539 HANNA 21014 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. should be filed within 72 hours after d and Mental Hygiene.

is marked other than "natural", or i Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 😾 No Specify Specify: WHITE 3√□ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALES CASHIER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NETTIE FRITZ LLEWELLYN LLEWELLYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 539 HANNA RD BEL AIR, MD 21014 JEAN DRAKE-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 12/16/11 GLEN BURNIE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySCHIMUNEK FUNERAL HOME OF BELAIR 610 W. MACPHAIL RD BEL AIR, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ ACUTE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant a 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 7 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available pe IT Dichetes. Arteriosclewhe Circlisico ula Disaix 24a. Was an prior to completion of cause of death? performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 🏹 npatient 2 🗆 ER/Outpatient 3 🗆 DOA ္ဝ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 29c. License number D0056607

State

Registrar

DHMH 17 Rev 7/2009

208

PLUMTREE Rd, BEL ADR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANGELO

31. Date filed (*Month*, *D*ay, Year) **DEC 1 6 2011**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 For State Registrar 40269 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 12, 2011 Physician/ 0320 а м Kenneth Dunlap Hampton, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Min. June 12, Yea(1)944 Days Hours Washington, DC 220-42-4404 67 Director 1 **X** M 2 □ F ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2X No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1215 Turkey Point Road 21037 death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married and 2 should be filed within 72 hours after the fleath and Mental Hygiene. It is marked other than "natural", or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1968-74 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Master Electrician Construction 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ellen Souder Kenneth Dunlap Hampton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia B. Hampton/wife 1215 Turkey Point Rd. Edgewater, MD 21037 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 12/16/11 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hutury Physician/ Coronary disease ROW disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be determed. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? J Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypoventilation 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 🗌 Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 💆 No Hospital Other: ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific D46052 12/13/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) whway anapolis oup

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ean 00 12 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Mondond Medical Baltimere MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗸 F (Month, Day, Min MaryTand Yrs. Director -11-20 Usual Residence of Decedent 28a-f shov : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 USA 1761 Clifview Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Holman Crystal Keith permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (MOther) 1761 Clifview Ave., Baltimore, MD 21213 Crystal Vaughn 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Barneter Green (Name of Corp. Parker place) @ Loudon Park 1 Burial 2 Cremation 3 Removal from State 12/14/11 Baltimore, Maryland any injury 4 Donation 5 Other (Specify) Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ extreme premuturity Due to (or as a consequence of): disease or condition resulting in death) Medical **Examiner** encemalocele Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ig physician and as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 2 N 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 🗌 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

0 Records, within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital To the Hospital or Attending

> State Registrar

29a. Certifier

(Check

only one)

30. Name and addr

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

St. Britimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ <u>December</u> 11:00 a^M Laura Nell Hill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Forest Hill Hart Heritage Estate 8. Date of Birth (Month, Day, Nov. 12 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Country)
Oklahoma Funeral Days Hours 1 M 2 X F Director 514-07-4162 91 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location Director 1 Yes 2 X No Johnson City Tennessee Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 37604 2113 Sinking Creek Road 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) College Teacher <u>5+</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry (unk) Loyd Laura (unk) Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Henry Hill / Husband 2111 Winstone Ct., Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Joppa, Maryland Mtn. Christian Cem. 12-15-11 4 Donation 5 Other (Specify) 22. Name and Address of Facility
McComas Funeral Home
1317 Cokesbury Rd... 21. Signature of Tureral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RUMENIIA Immediate Cause (Final END Stan YEARS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of). it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed e Hospital or Attending Physician: The law requires 2.24 hours affect death.
e Funeral Director: After this certificate has been six elemental director, page 2 should histed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 47.60 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: CAN 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number December 14, 2011

10

State Registrar

DHMH 17 Rev 7/2009

W. MARPHAIL

BULDIN MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registry 's Sign

ALFRED SPARKS

6 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# [perPHYS#20b, c, perFH, G922, 12/16/2011, ws]

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day P Month **₽** м Physician/ Jr. Medical 4b. City, Town, or Location of Death Baltimore 4c. County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Sinai Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Y Country) 212-60-4501 52 MD 1**X** M 2 □ F 11 **Director** Yrs. 59 HENSON, Andrew B 28a-f shov 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No Baltimore NA MD 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? U.S.A. 23a Funeral 21215 2835 West Garrison Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 XDivorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12th grade (0-12) College (1-4 or 5+) Social Security Adm Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vera Evans ည Andrew B. Henson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2835 West Garrison Ave, Baltimore, Md 21215 19a. Informant's Name/Relationship (Type, Print) Marion Stanley-Fiancee 20a. Method of Disposition 20b. Place of Disposition (Name of Pikesville Date Brate Arene Pag ather place)

19 | Hemorial Park 12/16/2011 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State Woodlawn, 4 Donation 5 Other (Specify) 21. Signature of Fuseral Service Lice March F/H West 21215 Md Baltimore, 4300 Wabash Ave, 23a. Part 1. Each the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate In erval Between set and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Physician: The law requires that the death certificate be executed and -trar Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performe certificate 2 🗌 No 1 Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita Other: 2 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the Mest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signa 201 30/Name and address of person who comp 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 06-2011

Known as

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death I1, 6:29 P M December 2011 Theresia M. Hamas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Montgomery Victoria Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 1 M 2 X F Hours January 10, Country) 214-54-3851 84 Japan 1927 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Maryland Montgomery Gaithersburg 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country? 207 West Deer Park Road 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etclian-1 Never Married 2 X Married Yes Yes, Giv 2 X No 1 ☐ Yes 2 🔀 No Specify. Specify: Asian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Artist Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hatsutaro Harada Ichi Nishi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Hamas, Jr. / Husband 207 West Deer Park Road, Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Place of Disposition (Name of December 15. 20c. Location - City or Town, State Montgomery or other place) Crematorium, Inc. 1 🔲 Burial 2 😾 Cremation 3 🗀 Removal from State 2011 4 Donation 5 Other (Specify) Bethesda, Maryland . Sign flure AFung | Service | Censee Robert A. Address of Facility Funeral Home, Bethesda-Chevy Chase, 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Years Immediate Cause (Final Alzheimers Dementia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy

Ph_sician/ Medical Examiner

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Baltimore, Maryland 21215-0036

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Examir Physician/Medical Completed by Be

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use ō should page 2 မ Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and nding physician and use as the burial-trar signed by the at Id be detached for funeral director, completed filled in by the To the Hospital or within 24 hours a To the Funeral D

Division of Vital Records, P.O. Box 68760

20 V State

1 Yes 2 No	4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown	Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?
Atrial Fibrillat	ion	1 Yes 2 X No 3 Probably 4 Unknown
	2:	4a. Was an autopsy performed? ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Death (Check only o	one)
1 Yes 2 X No	Hospital: 1	Assisted □ Residence 6 1 Other (Specify) Living
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not	28a. Date of injury (Month, Day, Year) 28b. Time of injury N 28c. Injury at work? 1 Yes 2 No	escribe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Lo	ocation (Street and Number or Rural Route Number, tty or Town, State)

Certifier	1 X Certifying Physician: To the best of my knowledge, death occur	ed at the time, date and place, and due to the o	cause(s) and manner as stated.
only one	2 Medical Examiner: On the basis of examination and/or investigation	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stat
only one	3 Certifying Nurse Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
Signature	and title of certifier	29c. License number	29d Date signed (Month, Day, Year)

ecevater 12,2011

dress of person who completed cause of death (Item 23a) (Type, Print)

911 Russell Avenue, Gaithersburg, Maryland 20879 M.D Melnick,

Registrar

11-09287 Donald Howard Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onald Howard		I- For State	ate of Maryla		artment of rtificate of		and	Menta	Нус		Dag No	20		40	27
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, Middle	e,Last)			ard				. Date of De	Reg. No. ath Day er 9, 2011	Year	3	Time of Death	
		Donald 4a. Facility Name (if not institution Sinai Hospital	n, give street and nu	mber)		b. City, Tov		ocation of D		Decembe		unty of [Death	- ·- <u>-</u>	
Funeral Director			6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under		If Under 2 Hours	24Hrs. Min.			5 F	9. Birthp oreign Count	lace (State or ry) MD	
MD 21215-0036 ad 2 should be filed within 72 hours after death with 1 th and Mental Hygiene. m 27 is marked other than "natural", or items 23; aumatic event, the Medical Examiner must be not	To Be Completed by Funeral Director	15. Decedent's Education (Special Elementary/Secondary (0-12) 1 2th grade 17. Father's Name (First, Middle, James Howard 19a. Informant's Name/Relations Johnson Joanne Howar 20a. Method of Disposition	Heights 12. Was Dec Armed For 1	B AVE redent Ever in U prices? 2 X No rede completed) -4 or 5+)	16a. Decedent during mo Aut	10°C 2 s Decedent ss, specify (Yes 2 X 's Usual Octoor Me Address i berttion (Name	of Hispacuban, No No coupation ng life. D cha (Street a	anic Origin Mexican, P specify: In (Give kin DO NOT us In 1C I. Mother's I Berni and Numbe	d of wo e retired	rk done d) First, Middle, Beth ral Route Nu	Specific Spe	Race - / White, excity: E of Busin	Country, A. America etc. 81ac hess/ind Shc	ip Code)	No
Physician /Medical /xaminer		1 Burial 2 Cremation 4 Donation 5 Other Sp 21. Signature of Funeral Service 23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	ecify: Licensee complications that e on each line. a. Idiopa Due to (or as a b.	aused the death	430 n. Do not enter the almonary of):	e ame and AcCh FOO Wa	bas dying, su	f Facility West sh At uch as card	7e,	Balt espiratory a		or heart	Md 2		
oe execut ician and irial - tra	hysician/I	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	Due to (or as a d. X AMENDED 7 2 3 a 1 23 c. If yes, 1 Live b 4 Pregn 9 Unknown	outcome of pregorith nant at time of decown	of): h,G924,2/0 per ME g panancy 2 Fet eath 5 Oth	al death	3 [y)	Ectopic p	regnand		Mo	ate of de	Da		
1 of Vital Records, P.C. ling Physician: The law requires that After this certificate has been signed t funeral director, page 2 should be deta	: To Be Completed by	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pend 2 Accident Invest	26 3 DO	2 COTONARY 1 Yes 24a. Was autop perform to perform the performance of Death (Check only one) 3 DOA Other 1 Nursing Home 5				ppsy prior to completion of cause of death?			nown ailable se of				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification	3 Suicide 6 Could 4 Homicide deter 29a. Certifier 1 Certifying Pr	d not be mined (Specify) systcian: To the best and manner s	et of my knowled		red at the ti ion, in my o	me, date	e and place	e, and d	or Town, ue to the ca	State) use(s) and me and place,	anner a	s stated		r, City
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Margaret Mary Hipp 2011 Dec. 11:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Drive Baltimore Glenrae Catonsville Social Security Number 6. Sex If Under 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 219-16-6890 1 - M 2 X F 89 10/17/1922 Maryland Usual Residence of Decedent 28a-f show the Maryland notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Catonsville 1 🗆 Yes 2 😾 No Maryland Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral with Glenrae Drive United States items permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Ves 2 **X**No If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ₩ Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ J. O'Brien Rose Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence O'Brien/Nephew 223 Glenrae Drive, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metro Crematory Inc. 12/14/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ corelina disease or condition arteriacrocar 10 year Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the attending physician and ched for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
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1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No signed by the atte d be detached for Month Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, ate has been sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No ☐ Yes 2 No 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 2 No Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at M Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 06-2011

State

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vience

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gallager.

29b. Signature and title of certifie

only one

Laurence R.

405 Frederick Rd.,

32. Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

1 7 8

Suite 206, Baltimore, MD 21228

29d. Date signed (Month, Day, Year,

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21215-0036	/2 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed by	3 Widowed		If Yes, Give Year or Dates.	E-F INO		1 ☐ Yes 2 🛣 No	Specify:			Specify:	WHITE
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Division of Vital Records, P.O. Box 68760	been signed by the s			icant conditions	s contributing to death	but not res	ulting in the u	nderlying cause gi	ven in Part I.	236	e. Did tobac	co use contribute t	to the cause of death?
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r item		11. Marital Status		12. Was Dec Armed Fo	orces?	in U.S.	13. V	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)			e - Americ k, White,	can Indian, etc.	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	20a. Method of Disp			2	0b. Place	of Dispo	sition (Name of natory or other place		Date		Location -			
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The law requires that the death certificate cate has been signed by the attending physpage 2 should be detached for use as the consistent by Dhugisian Manai	Neg	IF FEMALE:		Ogo If you ay	taama af n						Ī				
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ending sath. or: Afte he func	2	1 Accident	5 Pending Investigation	on	nth, Day, Yea	ar)	injury	work			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,			
I or Attending P after death. Director: After t in by the funera		3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could not determined	28e. Place	of Injury - ing, etc. (Sp		arm, stre	eet, factory, office		28f. Location (City or Tox			r or Rura	Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-fransi.	2	29a. Certifier 1	Certifying Ph	ysician: To the b	pest of my k	nowledge	, death c	occured at the time	, date and place,	and due to the ca	ause(s) a	and manne	r as state	ed.	
the Ho hin 24 the Fu applete		only one) 3	Certifying Nu	niner: On the bar rse Practioner:	sis of exami To the best	nation and/ of my knov	or invest wledge, c	igation, in my opinio death occurred at th	e time, date and p	at the time, date a lace, and due to the	ne cause	e(s) and mai	nner as st	tated.	r stated
vit cor		29b. Signature and	title of certifier	uni,	MD			29c. License				ate signed		Day, Year) , 2011	
.	-	30. Name and addre				(Item 23a)	(Type, P	rint) . ^	, 0						
11		Abd alla 31. Date filed (Monti	h Kafi	OUNI,	, 546	01 0	ld C	ourt Ro	ad, Ka	naalls1	DW	N.F	12)	21133	
State			n, Day, Year)	32. F	Registrar's S	igrature	back	1							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John V Medical 4a. Façility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Himore If Under If Under 2 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Country) 216-42-1369 1 XM 2 🗆 F Months Days Hours Min. (Month, Day, Year Director 0 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No ō 10e, Street and Number 10g. Citizen of What Country? "natural", or items 23a Funeral OV 2/030 death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify: Completed 3 Divorced 4 Divorced any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) NIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John 19a. Informant's Name/Relationship (Type, Print) Cockeysville, MD 21030 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 12/17/2011 Baltimore, MO Conation 5 C Other (Specify) March FIH East 1101 E. North Ave 22. Name and Address of Facility 21. Signatur of Funeral Service Licensee Baltimore, MD art I. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Im e ate Cause (Final di ear or condition res ling in death) Onset and Death ASCUD Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 🗌 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nuer this certificate has intuneral director, page 2 s autopsy performed. 1 🗆 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D0069314 12/14/11 who completed cause of death (Item 23a) (Type, Print)
(a) a Pat Randale Mo Pv o

DHMH 17 Rev 7/2009

State Registrar 32. Register's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death December 1/2, 2011 1200 Physician/ Rita Jane Joseph Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard 3518 Garratt Court Ellicott City 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, New York 214-64-1215 1953 **Director** 1 □ M 2 🗶 F 58 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State at Director notified 1 Yes 2X No Ellicott City MD Howard 10a. Citizen of What Country? 10f. Zip Code ō 10e. Street and Number Examiner must be USA 21042 items 23a Funeral 3518 Garratt Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. "natural", or þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F Neal Aronson Shirlee Friedman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3518 Garratt Court Ellicott City, MD 21042 Nrsingha Joseph of Health 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 12/15/11 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of
Important; If it
any injury or o 1 Burial 2X Cremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville. MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failube. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC OUTAIAN CANCEN disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 2 No 1 Yes 2 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 24 hours after death. autopsy performed' death? 1 Yes 2 No Yes 26. Place of Death (Check only one) completely filled in by the funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manny Certificate: Natural 5 Pending Investigation Could not be Accident Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and ti 29c. License number dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Outant AICE 700 ASIM

State

Registrar

31. Date filed (North, Day, Year

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 | 1 - For State Registrar Certificate of Death Thirtean 2. Date of Death 1. Decedent's Name (First, Middle, Last) seconber Day 46 AM 2011 Wayne Sourner 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Good Sananton Backmore Homore Cit 7. Age (In was last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 03/14/1952 5. Social Security Number Days Hours 1 M 2□F 218-60-5193 59 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2719 E. Northern Pkwy 21214 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mechanic 12 Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lowell Journey Joan M. Hutchins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frances Lambright/ Law 2924 Glenmore Ave. Balto, MD 21214
Lice of Disposition (Name of Date 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 15, Beltsville, MD Chesapeake Crem. 2011 22. Name and Address of FaciliFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licensee MO1585 Rebo Hackeymon 8717 Green Pastures Dr. Balto, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Bladder if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages Department of Important: If it any injury or c

Physician

/Medical

Examiner

Funeral Director

by

Completed

Be

MD

Funeral

Director

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If itam 27 is marked other than "naturel", or Itams 23a or 28a-1 show ury or other traumatic event, tra Modical Examinational and united and the modified at

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

The law requires that the death certificate be executed burial-transit use as the the funeral director, his Hospital or Attending I After Director within 24 hours a To the Funeral L

à Completed

29b. Signature and title of certifier

Examiner Physician/Medical Medical

State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Allaknown 24a. Was an autopsy perform 1 ☐ Yes 2/2/No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ENOutpatient 3 DOA 27. Manner death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 tural 2 Accident 5 Pending investigation 1 Tyes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

H0068991

29c. License number

29d. Date signed (Month, Day, Year) hirteenth, 2011

Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

56014 och Raven Blud 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40281 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Soon Rak Jeon December 2011 1:03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🖺 F Min Feb 24, Korea Months Hours 91 Director 217-63-5636 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 No Maryland Wheaton Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò other traumatic event, the Medical Examiner must be 23a Funeral 20902 USA 4011 Randolph Road items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married ò þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 😾 No Specify: Asian If Yes, Give Specify. "natural", 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 Is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Unk. Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is any injury or other trau 2405 Hermitage Avenue Silver Spring, MD 20902 Soo Jin Jeon, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Burlal 2 🔯 Cremation 3 🗆 Removal from State 12/15/11 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Toomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Mary Maryland 21228 ymai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause do each line. Interval Between Onset and Death Immediate Cause (Final Physician. Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events and -tran resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No signed by the a a 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alzheimer's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law performe certificate 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28c. Injury at 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work' 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 12/07/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Alan R.

Hugo Cir Silver Spring, Maryland 20906

1517

32. Registrar's Synature

Segal MD

31. Date filed (Month, Day, Year) **DEC 1 6 2011**

40282 State of Maryland / Department of Health and Mental Hygiene 2 1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KELLER Physician/ 17:50 PM JANE DECEMBER 12 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N/A HOPKING Johns Itaspita. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 3, 1964 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Security Number **Funeral** Months Hours Trinois 322-68-3426 Director 1 □ M 2 🏝 F 47 ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director York 1 Yes 2X No York 10f. Zip Code 17406 10e. Street and Number 10g. Citizen of What Country? 3690 Sorrel Ridge Lane USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married ould be filed within 72 hours after und Mental Hygiene.

marked other than "natural", or 9 Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Residence Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Ann Barnette Purna Nanda Saikia . Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3690 Sorrel Ridge Lane-York, Pennsylania 19a. Informant's Name/Relationship (Type, Print) Mark S. Keller-husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Important: If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗶 Removal from State Susquehanna Memorial Dec.16,2011 Gardens York, Pennsylvania 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, Maryland 21234 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Immediate Cause (Fi linease or condition resulting in death) FUNGEMIA Physician/ Medical Due to (or as a consequence of):

IMMUNE SUPPRESSION Examiner Sequentially list conditions it any, leading to immediate cause. Enter Underlying Due to for as a consequence of Cause (Disease or injury as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy
Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death signed by the ar 1 ☐ Yes 2 ☐ Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law autopsy performed? death? 1 Yes 2 No this certificate 25. Was case referred to medica Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: hours after death. 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C completely filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29d. Date signed (Month, Day, Year) le of certifie 29c. License number 29b. Signature and DECEMBER 12 2011 RES-000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St. Baltimore MD 2287 RNacu takis 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 230AM 2011 Medical Herman Joseph Kolakowski 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death County of Death Air Health of Rehabilitation tarto Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In vrs. last birthday) If Under 8 Date of Birth **Funeral** 1 🕅 M 2 🗆 F Months Hours **Director** 85 212-20-3001 1/14/1926 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heelth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Upper Falls MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11547 Franklinville Road 21156 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give
Year or Dates. WW II 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) 8 Police Officer Police Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 injury or other traumatic Julian Kolakowski Michaelena Wudkwych 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine M. Kolakowski (wife) 11547 Franklinville Road - Upper Falls, MD 21156 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I cemetery, crematory or other placem. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/17/2011 Baltimore, Maryland Sacred Heart of Mary 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. any as 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onse and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a sonsequence of, Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No or Attending Physician: The law requires that the death Month Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes Other: ပု 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death. To the Funeral Director: After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Division 1 Tyes 2 No Investigation Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Prontioner: To the best of my knowledg 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 510 Upper Scott Haswell MD Chusapenki 31. Date filed (Mo th State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $12 - 15 - 2011^{\text{Day}}$ Millard Byrd Knowles 5:45A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balto. Parkville Oak Crest Village If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav 8. Date of Birth **Funeral** 1 M 2 □ F 11-17-1929 216-22-0702 Director 82 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d Inside City Limits Examiner must be notified at Director 1 Tes 2 No Md. Balto. Parkville 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Completed by Funeral 8834 Walther Blvd. 21234 USA items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian Black White etc. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pastor Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James B.Knowles Emma J. Melchior any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin K. Wallace DTR. 2170 Willowick Square Columbus, Ohio 43229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burie 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith 12-17-2011 Balto. Md. of Funeral Service License Schimunek FuneralHome, .Inc. Signature 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Atherosclerotic Cardiovascular Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Millord B. Knowles IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed I director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Cerebrovascular Dueax Multi-infact Dementia, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Matural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/15/11 R171944 CRAP MSN completed cause of death (Item 23a) (Type, Print)

100

State

Registrar

82. Registrar's Signature

8800 Walther Blvd, Parkville MD 21014

Harrson

1 6 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		1	For State Registrar	State of Ma	aryland	•	rtment of H		Re	g. No. 2) ,	40285
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and the	Funeral		MANOR CARE RUZ 5. Social Security Number 6	. Sex 7. Ag	e (In yrs. la	st birthday)	TOWSO:	If Under 24 Hrs.	8. Date of Birth (Month, Day,			ace (State or Foreign
	Funeral Director		219-16-8268	1 🕅 M 2 🗆 F	89	Yrs.	Months Days	Hours Min.	08/11/19	22	000771	MD
	w w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10	d. Inside City Limits
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	ems deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - America ick, White, e	an Indian, tc.
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Maryland	should be filed and Mental Hygi s marked other umatic event, II	٥	LOUIS 19a. Informant's Name/Relationshi	(Type Print)	KAND		ng Address (Street		ral Route Number,	City or Town		
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re,	- I & =		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other place	ce)	Date 2	20c. Location		wn, State
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alt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service	оспасо			2. Name and Addre	3	OL LEVINS			
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6876 <mark>0</mark> ,	ficate p phys s the	edical		d								
Box (Attending Physician: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the buriat-transit.	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregna	ncy death 3	☐ Ectopic pregnand	ev.			Date of delive	•
O. B	deat he atte ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant			Other (specify)			'	Month	Day Year
P.	res that the de signed by the a be detached t	Phy	9 ☐ Unknown Part II. Other significant conditio		but not resu	ulting in the I	inderlying cause giv	ven in Part I	23e. Did tol	bacco use co	ntribute to t	he cause of death?
	ires th signer	þ	Part II. Other significant condition	is contributing to death i	but not resu	nung in the t	indenying oddoo gr		1 □ Y	es 2 No	3∐ Prob	pably 4 Onknown
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Division of Vital Records,	⊒ Di afte o	Certification: To	4 Homicide determi	ned building, e	etc. (Specify	y)	reet, factory, office		City or Tow			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the bes	of examina	wledge, dea tion and/or i	th occurred at the to nvestigation, in my	time, date and plac opinion, death occ	e, and due to the curred at the time, of	cause(s) and date and plac	manner as e, and due t	stated. to the cause(s)
•	To the within To the comple	Me	29b. Signature and title of certifier	Som	-	-		se number		29d. Date sig	13 - 1	
	10		30. Name and address of person	2 m 1 -	death (Iten	n 23a) (Type			<u> </u>	CON	mo	21204
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 40286 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 12 Physician/ 2011 William F. Loeffler 18:42 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Days Hours **Director** 218-32-7036 1 🛛 M 2 🗆 F 09/02/1937 Maryland 74 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Forest Hill Harford 0 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be a Funeral 1729 O'Conner Road 21050 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Vietnam Year or Dates. 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse Corp. Program Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward J. Loeffler Kathleen P. Lehane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1729 O'Conner Road - Forest Hill, Maryland 21050 Patricia Loeffler (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gdns. 12/17/2011 | Fallston, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assa 11750 Belair Road - KIngsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? is certificate has been signed director, page 2 should be de Completed by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 🗌 No Yes 2 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ျ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 5 Pending 1X Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOO 63220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Dr Bei Air mo 21014 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ <u>12/08/2011</u> Joseph L. Loverde 2:30 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7760 Catherine Ave. Pasadena Anne Arundel 5. Social Security Numberunk If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 A Months Hours Min Maryland 60 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 Yes 2 XNo MD Anne Arundel Pasadena 10e Street and Number 10f. Zip Code 6 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 21122 USA 7760 Catherine Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian. 11. Marital Status Armed Forces?

1 Ves 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married hours after Maryland 21215-0036 White 1 Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver Courier Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. Julius Loverde Alice E. Gerecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosina Loverde / Sister 7760 Catherine Avenue, Pasadena, Maryland 21122 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 12/14/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) gn turi of Funeral Service Licensee 22. Name and Address of Facility Baltimore, MD 21229 Hubbard Funeral Home, 4107 Wilkens Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Hear Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) 13 moth Examiner Atral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine the burial-transit Hypertension attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 No this certificate After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending death. To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu Investigation ☐ Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-12-11 9 D60842 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) elch A. Pa 3001 S. Hanover st. Baltimere, MD 2/22 32. Registra s Signa State

Registrar

1 - For State Registrar

			1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		Voor	3. Time of Death
	Physici /Medi		Albert F. McGowan				12	Day 14	2011	915 AM
3	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death			unty of Death	
1			FRANKLIN Square Hospital Co			sedale			retime	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. In March 2 F 70	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	v, Year)	Cour	
	Director		212-40-5562 XX ^{VIII} 70 Usual Residence of Decedent	110.			July 14	, 1941	Balti	more, Marylan
	/land			, Town or Lo	cation				1	0d. Inside City Limits
	Many P-f sh	ğ	Maryland Baltimore Ros	sedale						1 ∐ Yes 2√ No
	or 282	irec	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Coun	try?
	th wit	Funeral Director	2 Capella Court		21237			Unite	d State	es
	ems ems	ne	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White, e	
36	or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		1 ∐Yes 2 ဩrNo	Specify:	, , , , , , , , , , , , , , , , , , , ,			nite
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Evaniant must be notified at	Completed by	3 Wildowed 4 Li Divorced Year or Dates:							
햣	n 72 "'nat	Sete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. King (of Business/Ind	ustry
72	withi iene. thar	E	Elementary/Secondary (0-12) College (1-4or 5+)	_	eman	ω)		Gene	ral Ele	ectric
D	filed I Hyg other ent, I	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,			
al	fenta fenta rked clc ev	To B	Francis Curtain McGowan			Anna Lou	uise Mar	garet	Saffer	:
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Numbe	er, City or To	own, State, Zip	Code)
Σ	alth a		Sandra McGowan (Spouse)	2 Car	pella Cou	ırt Roseda	ale, Mar	yland	21237	
altimore, Maryland	of He of He item		20a. Method of Disposition 20b. Pl	ace of Dispo	sition (Name of	ce) [Date	_	ion - City or To	wn, State
Ĕ	Page nent int: H	١,	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	dens of	Faith Ceme	etery Decen		Rosec	lale, Ma	ryland
<u>=</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evander or other traumatic event.		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ess of Facility				
<u> </u>	99 = 29	8 3	Chilly Colli	1	8800 Har	eral Chapel ford Road R	arkville,	Maryla	nd 21234	rville
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition							Onset and Death
	/Medical Examiner		resulting in death) Due to (or s a consequ	ence o):						
	LXaIIIIIICI		Sequentially list conditions, If any, and the it immediate.		orax					
) e-	ted 1sit	Examiner	Cause, Chicer Underlying Cause (Disease or injury	ence of						
9	and and	xan	that initiated events c	ence of):						
9	e be e siciar buria	<u>e</u>	` - '							
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	cian/Medical	d							
ŏ	h cerl endin use a	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		1			23d	. Date of delive	ery
	deat e atte	icia	in the past 12 months? 1 Ves 2 No		Dectopic pregnance Other (specify) _	У			Month	Day Year
<u>Р</u>	w requires that the d been signed by the should be detached	Physic	9 ☐ Unknown							
_ ທົ	es tha	by	Part II. Other significant conditions contributing to death but not result	lting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to th	ne cause of death?
b	equir sen s ould	ted					1 🗆 Y	es 2 1	No 3∏ Prob	ably 4 Onknown
Ö	law r las be	ble					24a. Was a	an 2	24b. Were auto	psy findings available inpletion of cause of
<u> </u>	The cate h	Completed					perfor 1 ☐ Yes	med?_	death? 1 □ Yes	•
Įį.	clan: ertific	Be	25. Was case referred to medical examiner?			26. Place of Death	n (Check only o	ne)		
5	Physician: The law this certificate has al director, page 2 a		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ E		t 3 □ DOA Oth	er: 4 Nursing Ho	me 5 🗆 Resid	ence 6	Other (Specif	v)
ב	ding Phy h. After thi funeral o	io io	1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe h	ow injury o	ccurred	
Sic	ttend leath tor: the f	icat	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □No	201			
Division of Vital Records,	or Al	Certification: To	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, stre	et, factory, office		28t. Location (S City or Tow	Street and N n, State)	lumber or Rura	I Route Number,
_	spital ours ours eral filled		29a. Certifier 1 Certifying Physician: To the best of my know	vledne death	occurred at the ti	me date and place	and due to the	cause(s) an	nd manner ac s	tated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Examiner: On the basis of examinations) and manner stated.	ion and/or in	vestigation, in my o	opinion, death occur	red at the time,	date and pla	ace, and due to	the cause(s)
	Vithin Sompl	Me	29b. Signature and title of certifiet		29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)
			Ahmed MD		06	1337		12/11	4/11	
	140		30. Name and address of person who completed cause of death (Item	23a) (Type, I		1		/	XII	<u> </u>
1	0,1		DR Kirman's Ahmed 9000 FAH	nkliv	Squa	ie DR	Balt	0 11	s b	1237
	Sta	~	31. Date filed (Month, Day, Year) 32. Figisar's Signatu	ure 2						
	Registr	ar	DEC 1 6 2011 Severe	a. A.	arra					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2011

40288

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death George D. Metz Day 2011 ear Dec.13 3:000 M Physician/ Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rossville Manor Care / Rossville 8. Date of Birth (Month, Day, Year)
May11,1921 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Numbe **Funeral** Days Min Hours 216-18-1564 MD Director 1 🗚 2 🗆 F 90 Usual Residence of Dece items 23a or 28a-f show her must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a, State death with the Maryland Director Baltimore 1 Yes 2 X No Middle River MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21220 USA 8 Right Elevator Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Black White, etc. Armed Forces 9 Yes 2 **X**lo þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. Specify: White If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Martin Company Elementary/Secondary (0-12) College (1-4 or 5+) within the 10th Machinist Be other traumatic event, filed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Department of Health and Mental H
Important if item 27 is marked oth Besty Clark ပ George F. Metz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jennie Metz /wife 8 Right Elevator Drive Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 12/15/11 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility me and Address of Facility 300 Mace Ave. Connelly Funeral Home of of Funeral Service Licenses 21. Sign Balto. Md Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DISTINGE Immediate Cause (Final CARDIOVACULAR Physician/ THEROSCUEROTIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) been signed by the atter Month Day Year in the past 12 months? Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မ funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: I or Attending F after death. iniury 1 Natural 5 \square Pending Accident
Suicide within 24 hours after death

To the Funeral Director: A
completely filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Cert Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar , ly one

29h

Signature and title of certifier

6 201

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERPAL

9106, 32. Registrar's Signatu 29c. License number

PHILADRIHA RD

D0060560

29d, Date signed (Month, Day, Year)

#201, ROCEDALE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 11:10A M DECEMBER 1 2, 2011 Physician/ William B. MacLea Medical 4c. County of Death
BALTIMORE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON CENTER SAINT JOSEPH MEDICAL Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Hours Months Days 212-26-3049 Director 1 📈 2 🗆 F 1930 May 30. Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State Director 1 Yes 2 X No MD Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 5 Lombardy Place 21204 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 XMarried 2 🗌 No þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: If Yes, Give "natural" Completed 3 Widowed 4 Divorced white Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Industrial Sales Panasonic 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental H ည Anna Hull Robert H. MacLea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau / wife 5 Lombardy Place; Towson, MD 21204 A. Priscilla MacLea 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cren 20b. Place of Disposition (Name of cemetery, crematory or other place) Cremation 3 - Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 12/14/2011 Towson, MD 22. Name and Address of Facility 1050 York Road 21. Signature of Fin Towson, MD 21204 Ruck Towson Funeral Home, Inc. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or compleshock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. CONGESTIVE HEART FAILURE Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) the burial-transit Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant a Pregnant at time of death ed by the at detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa 23e. Did tobacco use contribute to the cause of death? been signed be should be det Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No Hospital: Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Xatural 5 Pending s after death. 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

To the Fune

completely fi Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a stated.

Certifying Nurse Practitioner of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 29d. Date signed (Month, 29b. Signature and title of certifier 29c. License number D25331 2011 30. Name and address of person who completed ERIC FISHER, M.D. of cause of death (Item 23a) (Type, Print)
Cause of death (Item 23a) (Type, Print)
TOWSON, MD 21204 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ 3:45 AM M 2011 6 Mildred Amelia McKenny . Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 7527 Bradshaw Road <u>Kingsville</u> 9. Birthplace (State or Foreign 8. Date of Birth Year If Under 24 Hrs. Age (In vrs. last birthday **Funeral** Min Hours 1 🗆 M 2 💢 F Maryland Director 07/30/1928 215-28-0997 22 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Kingsville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21087 U.S.A. 7527 Bradshaw Road Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black White etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced event, the Medical 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Keypunch Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Amelia Martha VonDracek Charles Masek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7527 Bradshaw Road - Kingsville, Marylan 21087 John C. McKenny 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 12/20/2011 | Bel Air, Maryland 4 Donation 5 Other (Specify) Bel Air Mem. Gdns. 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. . Signature of Funeral Service Licenses 60 <u> 11750 Belair Road - Kingsville, Marvland</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician Due to (ir as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to for as a consequence of, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live Birth
4 Pregnant
g Unknown in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes 2 ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 1 Yes 2 No this certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 hours after death. uneral Director. After this ed filled in by the funeral di 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending Investigation Accident 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral D

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and litle B

Registrar DHMH 17 Rev 7/2009

State

510

sistrar's Signature

HESAPEAKE DR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State amend 24 Registrar	, 26 per dr.	g922 1	2616	lificate of D	Death	-	Reg. No.	2011	10000
	Physicia Medic		1. Decedent's Name (First, Middle CHRISTA	e, Last) MEANN	JV				2. Date of De Month		30 Yedr	3. Time of Beath
(Examir		4a. Facility Name (if not institution SHADY GROVE	ADVENTIST	Hasait	ΔΙ	4b. City, Town, or ROCKV			l l	County of Death	MERY
	Funeral Director		5. Social Security Number		e (In yrs. last bii		If Under 1 Year Months Days		8. Date of Bir (Month, Da	th	9. Birthr	place (State or Foreign
	ind show at	j	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Tow	n or Loc	ation				1	0d. Inside City Limits
	Maryla 28a-f otified	Director	MD Mont	gomery	Roc	kvil	le					1 ☐ Yes 2 🎇 No
	h with the ns 23a or nust be n	Funeral D	10e. Street and Number 19667 Crystal	Rock Drive #	11		10f. Zip Code 208			10g. Citiz	zen of What Cour USA	ntry?
9000	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If You Give	Ever in U.S. No	l If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🌠 No	n, Mexican, Puerto	ecity Yes or No- o Rican, etc.)		14. Race - Americ Black, White, Specify: b1	
Maryland 21215-0036	thin 7%	Completed		ent's Education est grade completed) College (1-4 or 5 infant		(Give k	ent's Usual Occupa ind of work done d NOT use retired) infant	ation uring most of won	king	[nd of Business Ind infant	dustry
land 2	ould be filed wil of Mental Hygie marked other matic event, tt	To Be	17. Father's Name (First, Middle,		· · · · ·		unk	18. Mother's Nan Please	ne (First, Middle, ah Meanr		iurname)	
	nd 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relations Shady Grove Ad		ital 19	b. Mailin 9 901	g Address (Street a Medical	nd Number or Rui Center	al Route Numbe Drive F	r, City or 1 Rockv	Town, State, Zip (ille, MI	S ^{ode)} 20850
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (cemete		sition (Name of atory or other place	e)	Date	20c. Loc	cation - City or To	own, State
Balt	permit. Page Department of Important; If any injury or once,		21. Sign to: a Funeral Service	Pir	ector	1	ate and Addres 1timore,			Bal	timore S	Street
	nysician/		23a. Part 1 Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each line).	not enter		, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
-	Medical Examiner	Į.	resulting in death)	Pulma	a consequenc		Lypop	lesie				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a	a consequence	bf):	/					
09	ificate be executed ig physician and as the burial-transit	Aedical Ex	resulting in death) Last	Due to (or as a	a consequence	of):						
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as t	I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)	ý		2	3d. Date of delive	ery Day Year
ds, P.0	v requires that the sibole bis should be deta	ρ	Part II. Other significant condition	ons contributing to death b	ut not resulting	in the ur	nderlying cause give	en in Part I.				ne cause of death?
Recor	The law requi ate has been page 2 shouk	Completed							24a. Was autop perfo 1 □ Yes		24b. Were autop prior to co death? 1 \(\subseteq \text{Yes}	osy findings available mpletion of cause of
Ital	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ce of Death (Chec				
n of V	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	cate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi	1 A Inpatie 28a. Date of injur (Month, Day		utpatient Time of injury	28c. Injury work?	4 □ Nursing H	ome 5 Residence 28d. Describe h		Other (Specify occurred)
Divisio	al or Atten s after deal I Director: d in by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be		arm, stre		163 2 110	28f. Location (S City or Tow		Number or Rural	Route Number,
-	he Hospit in 24 hour ne Funera pleted fille	Medical	(Check 2 L Medical B	Physician: To the best of Examiner: On the basis of ex Nurse Practioner: To the	kamihation and/	or investi	gation, in my opinior	death occurred a	t the time date a	nd place :	and due to the cal	ise(s) and manner stated.
	To the company of the		29b. Signature and title of certified		lo		29c. License		7	29d. Date	signed (Month, L	Day, Year) 2011
		7	30. Name and addres of person		eath (Item 23a)	(Type, Pr	int)		1D 89	01 h	115 CONSI	N AVENUE RYLAND
	Stat	e	31. Date filed (Month, Day, Year)	S IEROCIC 32. Registra	r's Signatur	17	TANED	1	IN BE	THES	DA MA	RYLAND
	Registra		DEC 1.6	3 2011 Come	w B.	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40293 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15. DANIEL JOSEPH **MEBUST** December 2011 2:45A Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Gilchrist Towson 8. Date of Birth 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours 517-82-8777 12/28/1969 **Director** 1**XX**M 2 □ F 41 New Jersey Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director ms 23a or 28a-f s must be notified YX Yes 2 No Pennsylvania York York 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 621 East Market Street 17403 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Medical Examiner ed Forces Black, White, etc. 0 1 Never Married ģ 2 Married 1 XX Yes 2 ☐ No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify. White "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Chef Restaurant traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Leland Mebust Theodora Regina Gulhaugen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. John Leland Mebust Father 561 Brook Road Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial XXI Cremation 3 🗆 Removal from State cemetery, crematory or other place) GreenMount Crematory 12/16/2011 Baltimore, Maryland ☐ Donation 5 ☐ Oth (Specify) nature of Funery 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. 23a. Part 1. Enter the disease for complic shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ covcinent of cell months disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the SP IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death
Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify Mos PICE မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AARON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

CHANKS

1 6 2011

6701 N.

D 58303

Charles ST, TOWSON MM

29d. Date signed (Month, Day, Year)

December 15 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\Omega\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 4.37 pm SUSAN 12 12 2011 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) PARKWAY BALTEMORE BALTIMORE Pereing CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Par) (Pear) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. Marviand 1 □ M 2**XX**F 213-76-7308 56 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State 1 □Yes 2√√√ No Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 1801 Wentworth Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 200 No 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 □Yes 2XX If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Thelma Vernon Vere Leonidas Masters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18810 Walther Blvd #3114 Baltimore, Maryland 21234 Catherine V. Grahn Sister 20c. Location - City or Town, State 20a. Method of Disposition

1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/16/2011 Baltimore, Maryland Moreland Memorial Park □Donation 5 □Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funera Selvice Utense 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) SYNDROME 56 years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 ☐ Other (specify) ☐Yes 2MNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMER 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown DEMENTER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🕅 Natural

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a

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es 1 and 2 should be filed w of Health and Mental Hygier fitem 27 is marked other th

permit. Pages 1 a
Department of He
Important: If item
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within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

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other traumatic event, the Madical Examiner must be notified at

The law requires that the death certificate be executed and burial-trar attending physician the as nse 5 detached signed by been has page 2 s certificate the Hospital or Attending Physician: r this certifica After t

P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medical ģ Completed Be မှ Certification:

the Funeral Director: Af completely

within 7 2

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State

Medical

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number R152171

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

6095 Marshalee Dr. ElkerDGE ANAPOLSKY CRMP

31. Date filed (Month, Day, Year) **DEC 16**

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ December 4. 2011 3:20P Terrance Eugene Miles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 282 Harford 300 Sunflower Dr. Apt. BelAir If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Months 213-44-9264 **Director** Yrs. 66 6/28/1945 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 Yes 2X No BEL AIR MD HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 Funeral 300 SUNFLOWER DR. APT 282 USA r than "natural", or items the Medical Examiner mu death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after WHITE 1 ☐ Yes 2 🗓 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) CONSTRUCTION LABORER q Be 18. Mother's Name (First, Middle, Maiden Surname)
AUDREY WALLACE 17. Father's Name (First, Middle, Last) EUGENE MILES other traumatic and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Department of Health ar Important: If item 27 is any injury or other trau BEL AIR, MD 21014 300 SUNFLOWER DR. APT 173 GLORIA GIORDANO-SISTER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State GLEN BURNIE, MD ATLANTIC CREMATORY 12/13/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELATR Signature of Fune al Service Licensee BEL AIR, MD 21014 610 W. MACPHAIL RD ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Partyl. Enter the disease or complice shock, or heart failure. List only one of Immediate Cause (Final Physician/ 3 yrus Due to (or as a consequence of) disease or condition resulting in death) GIFTEN Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe-+01519~ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy the funeral director, page 2 Demention performed' 1 ☐ Yes 2 ☐ No this certificate Yes 2 No 25. Was case referred t edical examiner? 26. Place of Death (Check only one) Hospital: ၀ 1 🗌 Yes 2 1 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred s after death. iniury 1 Vatural 5 Pending Accident Investigation PA 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. filled in by 4 Homicide determined within 24 hours a To the Funeral C 🕊 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 the only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed c use of death (Item 23a) (Type, Print) Bel Air, Mdi

State Registrar 202

Mac

31. Date filed (Month, Day, Year) **DEC 1 6 2011**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 Month Physician/ Merbach 3112-12N December . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** throve HODKIN Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-44-1382 06/22/1946 65 MD **Director** 1 □ M 2 🌣 F items 23a or 28a-f show her must be notified at 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director MD Baltimore 1 ☐ Yes 2 🛭 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 Funeral USA 56 Township Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carman Bonovich George Little Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 Township Road, Baltimore, MD 21222 Merbach / Spouse Wayne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XXCremation 3 Removal from State Department of Important: If any injury or once. Chesapeake Crematory 12/17/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pheumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** small cell lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No be detached for Year Month Day 1 Yes 2 b P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Esophageal fishla Records, 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Pulmonary Embolum 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No the f ☐ Accident☐ Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) KF.S-000 pacember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rekha Rapako 600 Morth Wolfe Street, Bultimore mo 21287 31. Date filed (Month, Day State 1 6 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40297 Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) December 11, 2011 Physician/ 12:05 P M Edward Vincent Moroz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Waldorf 2746 Sprague Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Min. Apr 17, Year)947 Months Hours Pennsylvania 198-38-5161 64 **Director** 1**X** M 2 □ F Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director must be notified 1 X Yes 2 No Waldorf MD Charles 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5 Funeral items 23a 20601 USA 2746 Sprague Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Yes þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Special Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Josephine Gara Stanley Albert Moroz 19a. Informant's Name/Relationship (Type, Print)
Frances Moroz/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2746 Sprague Drive Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 12/16/11 Woodbine, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Alesidence 6 Other (Specify) ဂ္ 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Harvey I. Katzen, M.D. 8116 Good Luck Rd. Suite 100 Lanham, MD 20706

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) DEC 16 2011

December 13, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40298 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year KATHERINE 2:15 AM DECEMBER 201 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Town, or Location of Death **Examiner** BALTIMORE BALTIMORE CROMWELL CEN TE 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 F Months Min. 212-20-3356 88 **Director** Maryland 29, 1923 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at by Funeral Director 1 Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 21014 USA 802 Fox Bow Drive Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married ò more, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12th Homemaker Home marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Agnes Powers Daniel O. Worthington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 27 DTR Bel Air, Md. 21014 Mary Berend 802 Fox Bow Drive permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) 12-15-2011 Parkville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air dies MacPhail Road Bel Air, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BEMENTIA STA6E END disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of bunal-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical Box 68760 use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed bage 2 should be det 23e. Did tobacco use contribute to the cause of death? CELL ivision of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Matural injury 5 Pending 24 hours after death. Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) BO 32717 DECEMBER who completed cause of death (Item 23a) (Type, Print) 8710 EM66 ROAD MD PARKVILLE MI 31. Date filed (Month, Day, Year) Registrar's Signat State DEC 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMB 9:10 PM CHARD & MCADOC 9,201 ER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CECIL PERRY POINT AND. HEALTHCARE SYSTEM If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** . Age (In yrs. last birthday) Days Hours (Month. Day, 1 X M 2 🗆 F Months Min 768356 62 **Director** New York 1949 Usual Residence of Decedent or 28a-f shov notified at the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard 1 Yes 2X No Laurel 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 8534 Pineway Drive 20723 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 X Yes 2

If Yes, Give Black, White, etc. 1 X Never Married 2 Married δ 21215-0036 1 ☐ Yes 2X No Specify: 1970-72 Specify: White 3 Divorced 4 Divorced Completed Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Convenience Store Be **Maryland** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Donald McAdoo Mary Hilliard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen McAdoo/brother 9509 Park Avenue Laurel, MD 20723 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 12/16/11 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature Funeral Sey Ce Lice Going Home Cremation Service P.O. Box 784 Beverly MO1251 Heckrotte, P.A. Clarksville, MD 21020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to in medicause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exam attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 1 🗌 Yes 2 🔲 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I completed filled in by the funer. 1 🔀 Natural 5 \square Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 💢 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cer Hying Nurse Practioner: To the b at the time date and place, and due to the only one 29b. Signature and title of co 29d. Date signed (Month, Day, Year) hanas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYIAND HEALTH CARE SYSTEM, PERRY POINT, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed-(Menth, Day, Year)

6 2011

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 11:30 A Dec. Franklin Morningstar Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Lansdowne 104 First Avenue Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Hours **Director** 1**X**XM 2 □ F 75 217-34-2702 Oct. 5, 1936 Maryland Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State items 23a or 28a-f shoner must be notified at Director 1 Yes 2 No MD Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21227 104 First Avenue death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2XXNo Black, White, etc. ö 1 Never Married 2 X Married ρ Baltimore, Maryland 21215-0036 filed within 72 hours after White 1 ☐ Yes 2 X No Specify. If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Business Contractor event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental F ဂ္ Page 1 and 2 should be Helen Dixon John Franklin Morningstar Sr. other traumatic it of Health and h 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 First Avenue, Lansdowne Maryland 21227 Beatrice Morningstar-Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cemetery Dec. 16,2011 Frederick Maryland 22. Name and Address of Facility Ambrose Funeral Home Inc. Signature of Funeral Service Licenses 1328 Sulphur Spring Road Arbutus Maryland 21227 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Upuno disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death ed by the a detached f g Unknown g 🗌 Unknown been signed by should be detac 23e. Did tobacce use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of cate has autopsy performed death certificate 1 ☐ Yes 2 ☐ No 2 6 Yes Division of Vital funeral director, 25. Was case referred to _- dical 26. Place of Death (Check only one) Be examiner? Hospital: ဂ္ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director. After this completely filled in by the funeral di 27. Mann eath Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of o completed cause of death (Item 23a) (Type, 10 31. Date filed Worth, Day

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 12, 2011 Physician/ 10:15 PM Janice Ann McDade Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HRS **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 5 November 4, 1953 Hours New York 1 □ M 2 🕱 F 58 375-58-1149 Director 0 22 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director or 28a-f sl 1X Yes 2 ☐ No Maryland Rockville Montgomery 12/12/2011 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 0 "natural", or items 23a o Funeral United States 2001 Ashleigh Woods Court 20851 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 K Married Completed by Specify: White 1 ☐ Yes 2 🖾 No Specify. 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Medical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Herbert H. McDade, Jr. Ann Finucane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter D. Tietjen/Husband 2001 Ashleigh Woods Court, Rockville, Maryland 20851 TANICE Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of December 20. cemetery, crematory or other place)
Gate of Heaven
Cemetery Page 1 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Hawthorne, New York Signature of Funeral Service Lig 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue 20 M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury PNEUMONIA and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death ed by the a a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed b 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC 1 Yes 2 No 3 Probably 4 Unknown DISEASE Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an CHRONIC OBSTRUCTIVE PULMONARY Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has k sted filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 XNo MYELODYSPLASTIC SYNDROME Yes 2 X No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No မ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13 2011 DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 20850 ROCKVILLE MEDICAL CENTER DRIVE CARPENTER 9901 31. Date filed (Month, Day, Year)

DEC 1 6 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nunnaly Patricia Harris 5,2011 12:50PM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 - M 2 -Months (Month, Day, Year) 02/16/1946 578-60-0562 **Director** Washington, DC Usual Residence of Decedent a or 28a-f show be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director District Heights 1X Yes 2 □ No MD PG permit. Page 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than ""." any injury or other traumation. 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ems 23a or r must be r Funeral 5801 Marlboro Pike 20747 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U.S Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) Private 11th Dietician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Horace Williams Bernice Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207475801 Marlboro Pike; District Heights, MD William Nunnaly (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 12/12/2011 Suitland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitFreeman Funeral Services 20748 4594 Beech Road; Temple Hills, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director. After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L rem. __ Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Preumonic 1 Tes 21 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 H Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: ၉ ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital or within 24 hours aff To the Funeral Dis completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier KOMMU >69737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHEER SANIKOMMU 7503 SUIJOHS PO 31. Date filed (Month, Day, Year) DEC 1 6 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 40304 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ December 9 8:37 PM Nghiep Thanh Nguyen Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 01ney Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Davs Hours Min (Month, Day, Year) 586-50-4445 **Director** 1 **X** M 2 □ F 80 May 16, 1931 Vietnam Usual Residence of Decede 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 United States 3002 Castle Garden Way death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? 0 þ 1 Never Married 2 X Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Asian "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electronics Technician Defense Contracting ulth and Mental Hygie
27 is marked other
r traumatic event, ti Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Nguyen Thanh Nguyen Xung Kiem Tran Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 21704 Patricia N. Garvey/Daughter 3729 Spicebush Drive, Frederick, Maryland other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Gate of Heaven Cemetery 1 K Burial 2 Cremation 3 Removal from State December 17, 2011 ō Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland permit. Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 Signature of Funeral Service License M01173 Willia lun 23a. Part 1. Enter the disease, or compilerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequ **Examiner** Sequentially list conditions, if any, leading to immediate Examine burial-transit Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) the a been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\tau \) Nursing Home 5 \(\tau \) Residence 6 \(\tau \) Other (Specify) 1 Yes 2 No ဂ္ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Vinh Bichhuor M 754996 Vecember 15 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bichhuong M. Dinh, M.D. 18101 Price Philip Drive, Olney, Maryland 20832

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 72, 2011 1734 Joseph Natoli Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital 8. Date of Birth (Month, Day, Mar 18, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday, Sex 1 M 2 □ F **Funeral** Months Hours Washington DC 1922 89 Director 577-28-6144 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 X Yes 2 No MD Prince George's Greenbelt 0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō and Mental Hygiene. 'is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral USA 20770 137 Northway within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 ☐ No Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 Divorced Completed Year or Dates. 1943-46 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Delicatessen Owner permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Grace Natoli Phillip Natoli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 Northway Greenbelt, MD 20770 19a. Informant's Name/Relationship (Type, Print) Barbara L. Natoli/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Final Journey Crematory 12/15/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD Signature of Funeral Service Lips MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Acute Cerchrovascular Accident disease or condition resulting in death)) Medical Examiner Hypertension Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dise to for east nonnequence of Coronary Artery Disease attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Property After this certificate has been signed by the attending physicial process. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? 2 X No Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify, 1 Inpatient 2 I ER/Outpatient 3 I DOA ည 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Acciden Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, 6383 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Padma Chirumamilla, M.D. 7600 Carroll Ave. Takoma Park, MD 20912

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

16

racke

2. Registrar's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 14, 2011 Physician/ Olive May Odham 3:30 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll County Finksburg 2215 Ridgemont Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Jan. 26, 1923 1 □ M 2 🄀 F 217-14-0531 Maryland Director 88 Yrs. Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10c. City, Town or Location 10a. State at Director notified 1 Yes 2 XNo Finksburg Carroll County Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ms 23a or must be r United States 21048 Funeral 2215 Ridgemont Drive tems Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status "natural", or iter edical Examiner Armed Forces? Black, White, etc þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or amy injury or other traumatic event, the Medical Examin once. 1 ☐ Yes 2 ANO Specify: White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) **N/A** Home Maker Own Home Be 18. Mother's Name (First, Middle, Maiden Surna 17. Father's Name (First, Middle, Last) Anna Elizabeth Bennett ည Jesse L. Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21048 2215 Ridgemont Drive Finksburg, Maryland Mr.Fred W.Odham, Sr. (Husband) Location - City or Town, State (Baltimore County) 20a. Method of Disposition 20b. Place of Disposition (Name of Monday Dulaney Valley Memorial Dec. 19, 2011 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Signature of Funeral Service Licenses L Timonium, Maryland 21093-2215 2325 York Road Lic.#M00677 art 1. Enter the disease, lock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death accider Immediate Cause (Final 95 (4/91 Physician/ e 640 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for an a nonerousing of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 mg Month Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed to should be det ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has blirector, page 2 s autopsy performed 1 Yes 2 No 1 Yes 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\to \) Nursing Home \(\text{Nursing Home} \) Residence \(6 \) Other (Specify No 1 🗌 Yes ည 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 24 hours after death. e Funeral Director: Ai bletely filled in by the fu within 2

To the F

complet

Baltimore, Maryland 21215-0036

Date of injury (Month, Day, Year) work?
1 Yes 2 No Natural injury 5 Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certif pleming 29c. License number D 2 3 kh3

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 17-15-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOVE BIVE WESTMINS LEV MI) 21157 NA (NN VALWALA ND 1130 Bailtimure BIVE Westmins Lev MI) 21157

State Registrar

le

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40307 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec Physician/ OWENS Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Examiner Gilchnist Hospice 10W5an 9. Birthplace (State or Foreign Country)

Mary large If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 212-74-9017 1 № M 2 🗆 F Director yland Mar. 3 28a-f show 10c. City, Town or Location at 10a. State 10b. County Director Baltimore 1 1 Yes 2 □ No items 23a or 28a-f s ner must be notified Maryland 10f. Zip Code 10g. Citizen of What Country 10e Street and Numbe USA Funeral Westwood Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. or, by 1 Never Married 2 Married 2 - No Yes Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Secondary (0-12) other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 N Chapelaate Lane HPT K But 9a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Marylan any injury or Men. T 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ar shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final PATOCPULVEARC Physician) AKCINOMA MAN NTH disease or condition Medical resulting in death) as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events at this independent.) DUE to for all a nonsequence of Examine ician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death ed by the a g Unknown Division of Vital Records, P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TYPE 2 DIABOTES MULLITUS 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an HEPATITIS autopsy perform death? 2 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 4 Nursing Home 5 Residence 6 other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d Describe how injury occurred Certificate: Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print) ddress of person who completed 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40308 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 9:00 AM 2011 Wolfgang W. 0ehme Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 212 Aighurth Road Apt 114 Baltimore Towson 9. Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. If Under 1 Year 8 Date of Birth . Age (In yrs. last birthday **Funeral** Hours Min (Month, Day, Year) Director 217-38-2121 1 🛛 M 2 🗆 F 81 May 18, 1930 Germany 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No MD. Baltimore Towson 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 212 Aigburth Road Apt 114 21286 USA items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married filed within 72 hours after all Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: marked other than "natural", Specify: White 3 Widowed 4 N Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Architect Landscape 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Elizabeth Newmann Walter 0ehme permit Page 1 and 2 should Department of Health and Mc Important: if item 27 is mark any injury or others 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 High Green Lane Stevenson, MD. 21153 Carol Oppenheimer/ Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 5 Other (Specify) Hillton Service Co. 12-16-11 Towson, MD. 4 Donation ^{22. Name and Address of Facility} Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature eral Service 1 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Sears Physician/ disease or condition resulting in death) ancer 0 ON Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the a Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completely filled in by the funer Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of cortifier Name and add son who completed cause of death (Item 23a) (Type, Print) AU

State Registrar 31. Date filed (Month) Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Home ltimor 8. Date of Birth (Month, Day, al Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days 8103 1 XM 2 □ F Hours Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD timor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗙 No Black, White, etc 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black Specify: 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) /Seconday (0-12) College (1-4 or 5+) Improve Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ird rna 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 St Burial 2 Cremation 3 Removal from State Kandallstown, MD 12/17/2011 ponation 5 Other (Specify) 21 Si nati re of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 Baltimore 23a a 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirck, or heart failure. List only one cause on each line. Approximate Interval Between In me vate Cause (Final Onset and Death infare tion Physician/ or condition in death) Medical Due to (or as a consequent Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director; After this certificate has been signed by the attending physician and burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as the b IF FEMALE: for use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown detached signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy director, page 2 perform 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 7 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) upleted filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 \square Pending 1 🔼 Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Lack Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 2 To the F

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State Registrar

(Check

only one)

29b. Signature and itle of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death

DHMH 17 Rev 7/2009

tem 23a) (Type, Print)

310.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Balt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:45A Theresa Maude Platania 1 4 1 15 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 135 Pointer Circle Anne Arundel Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 06/02/1945 1 □ M 2**X** F 66 New York Director 054-36-9819 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 28a-f 1 Yes 2 XNo Anne Arundel Glen Burnie 0 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 21061 U.S.A. 135 Pointer Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2 X Married Completed by 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Religious (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Catholic Church Director of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Schuster Charles Maude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph Platania / Husband Pointer Circle Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 12/19/2011 Crownsville, MD 21. Sanature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Cancer Physician/ Breast gears disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗶 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Tyes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title of certifier 29b. Signature a

State Registrar

10710

Charter Drives

Suite 6020

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Knight

B.

lement 31. Date filed (Month, Bay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12/12/201 Year 12:10 A M Albert A. Petrlik Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Summit Park Nursing & Rehab Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Davs Hours 4/13/1914 Maryland 1 🛛 M 2 🗆 F 215-10-2265 97 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland 벎 Director "natural", or items 23a or 28a-f s idical Examiner must be notified 1 ☐ Yes 2 😾 No MD Howard Woodstock 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21163 USA 11017 Doxberry Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 □ Divorced er than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Insulation Co. 12 0 Sales Be Department of Health and Mental H Important: If then 27 is marked out any injury or other traumatic mental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank J. Petrlik Theresa Sima 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. Timothy Petrlik / Son 11017 Doxberry Circle, Woodstock, Maryland 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 12/14/2011 Baltimore, Maryland Donation 5 Other (Specify) Bayview Crematory ure of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home E., Baltimore, MD 21229 4107 Wilkens Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myo Condial disease or condition Medical resulting in death) Due to (or a consequence of): Examiner oronaux at Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ò Day 5 Other (specify) Month Year Pregnant at time of death signed by the ar the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 X No has certificate 25. Was case referred to medical funeral director, 26 Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0058506 12.12.11 Mes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) whis 700 Geipe Rd. #200 Catonsville, Md. 21228 ind 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 40312 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Day Physician/ 0330 km rer ZOIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bat Himore 9. Birthplace Country) If Under 24 Hrs. Hours Min. 8. Date of Birth last birthday **Funeral** Months (Month Day Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Town or Location Director MD Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's Funeral 1218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ■ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Be Eather's Name (Mst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) FunerahService Lio Name and Address of Facility Approximate Interval Between Onset and Death er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failu Immediate Cause (Final disease or condition heart failure. List only one cause on each line Physician/ amo. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the luneral director, page 2 should be detached for use as the burlat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? iniurv 5 Pending Natural 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 201 Name and address of person who complete ed cause of death (Item 23a) (Type, Print) aro ter 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 11:00 AM Rohlfing Philip James December 12 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Samaritan Hospital (rood Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 20 5. Social Security Numbe 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Funeral MAryland 1 M 2 🗆 F 59 220-62-3264 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Maryland N/A Baltimore City 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Page 1 and ב מונים... Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items באי ביי ביי Important: If item 27 is marked other than "natural", or items באי ביי ביי יר other traumatic event, the Medical Examiner must be r Funeral 4906 Arabia Avenue U.S.A. 21214 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates. 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Associate Shoppers Food 12 vr's Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Wilfred Robert. Rohlfing Sr Cecelia Mc Donough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jovce Rohlfing - Wife 4906 Arabia Avenue Baltimore, MD 21214 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp Dec. 13, 2011 Towson, MD 22. Name and Address of Facility Signature of Funeral Service Licer Baltimore, Maryland 21214 eonard J. Ruck. Inc. 5305 HArford Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ en(our s disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ocourdial Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 人がんがん かんしん Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) s been signed by the s should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy Hospital or Attending Physician: The 1 Yes 2 No certificate Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Yes Inpatient 2 ER/Outpatient 3 DOA this (28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural work? 2 Accident
3 Spin 5 Pending ithin 24 hours after death.

the Funeral Director: Al
ompleted filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Fractioner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Fractioner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) och Raven Blud 6-7, Ballimore MD Abou Zahr 5601 31. Date filed (Month, Day, Year) State **DFC 16** Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 2 [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dec. 2011 4:40P Paul Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4629 Coleherne Road Baltimore 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🕱 M 2 🗆 F 01-31-33 Country) 218-28-0411 78 MD Director Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 ☐ No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 Funeral 4629 Colehere Road items 23a USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. African "natural", or 1 ☐ Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: American Completed permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) W.R. Grace & Co. Machine Operator 8th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charlie Rice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 19a. Informant's Name/Relationship (Type, Print) 4629 Coleherne Road Baltimore, Maryland Millie F. Rice-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12-19-11 Baltimore, MD 4 Donation 5 Other (Specify) Druidridge Cem. 22. Name and Address of Facility Wylie Funeral Home P.A. Signature of Funeral Service Licen 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cares on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law Jas autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital 2 X No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 X Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Investigation M within 24 hours after death

To the Funeral Director: λ
completed filled in by the f 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Wedical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29d. Date signed (Month. Day, Year) DDD5991 ss of person who completed cause of death (Item 23a) (Type, Print) George DURST. Baltimore, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2 12:50PM December ZYear DENISE S. ROZIER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL LANHAM 7. Age (In yrs. last birthday)
50 vrs If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** FEB. 9 1 🗆 M 2 🗓 F Months Days Hours Min MARYLAND **Director** 216-86-0629 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director 28a-f 1 X Yes 2 No PRINCE GEORGE'S CAPITOL MD 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code ems 23a or r must be r Funeral 315 YORKNOLLS DRIVE 20743 USA items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner any injury or other traumatic event, the Medical Examiner. Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Rower, Denise Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 XNo Specify If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE REGISTERED NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SHIRLEY M. HENRY LEON S. MITCHELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 YORKNOLLS DRIVE CAPITOL HEIGHTS, MARYLAND 20743 SHANIQUE ROZIER/DGT. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 12/16/2011 RIVERDALE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Dada Hoossyri resulting in death) Medical Due to (or s / consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death the a Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Itead Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 9 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 24 hours after death, Funeral Director: After this Time of injury at work?

7 M 1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Tim inju . Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending side of hospital Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be Place of Injury - 1 home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Ryral Route Number, City or Town, State) Dec 10 15 / 166 P. Good Luch 12d, Lan 112m, 4 Homicide determined hosp, Medical M Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nuyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) ė 70102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lankam, MD. 20106 8118 Good Luck Rd. mD. gama, 6 6 2011 32. Registrar Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 13 2011 Physician/ 9:00 A RICHARDSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 6218 ADDISON ROAD SEAT PLEASANT 9. Birthplace (State or Foreign . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth . Age (In yrs. last birthday) **Funeral** SEPT 14 1 M 2 X F Months Days Hours Min. 1928 NORTH CAROLINA Director 578-42-3529 83 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City. Town or Location Director Yes 2 No PRINCE GEORGE'S MD SEAT PLEASANT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6218 ADDISON ROAD 20743 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2X No Specify: BLACK Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH FOOD SERVICE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ GENERAL LEE CORA MACARTHUR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>LEWIS/NIECE</u> ADDISON ROAD SEAT PLEASANT, MARYLAND 20743 ELLA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ROLLING GREEN CEMETERY 12/17/11 PHILADELPHIA, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1 Approximate shock, o heart faill Immediate Cause (Final disease or condition resulting in death) Interval Between Onset and Death heart failure. List only one cause on each line aps Physician/ Sarcoma 20110g Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ate has been signed by the atte page 2 should be detached for: in the past 12 months? 5 Other (specify) Month Day Year Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2X No 1 Yes 2X No To Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 \(\to \) Nursing Home 5 \(\boldsymbol{X}\) Residence 6 \(\to \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 🗌 No Accident Investigation Suicide Could not be within 24 hours after de To the Funeral Directo completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical

31. Date filed (Month, Day, Year) State Registrar

title of d

29a. Certifier (Check

only one)

30. Name and addreg

29b. Signature and

Plus Scite 214 ARROSALU Medical 2003 32. Registra s Signature

Certifying Nurse Practioner: To the best of my knowledge, de

of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

061272

29d. Date signed (Month, Day, Year)

12/13/11

11-09225 Steven Ruby

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Ce Ce	ertificate		' and wichta	, ,	Reg. No.		
Physici		Decedent's Name (First, Middle,Last	1)				2. Date of Dea	ath Day Year	3. Time of Death	
Medical Exam	iner	Steven Murray 4a. Facility Name (if not institution, give	Ruby	·	Ab City To	own, or Location of D	Decembe	er 8, 2011 4c. County of E	0735 hrs	
		515 West 29th Street	s street and manifely		Baltim		,000	To. County of E	Joan	
Funeral		Social Security Number 6. Se	x 7. Age (In yrs	. last birthday)	If Under				9. Birthplace (State or oreign	
Director		217-74-4328 1X	M 2 F	53 Y	rs. Months	Days Hours	Min. 03/1	7/1958	Country) Maryland	
any		Usual Residence of Decedent 10a. State 10b. County	I10c. Cit	ty, Town or Loc	ation				10d. Inside City Limits	
*	_	,		•					1 X Yes 2 No	
Maryland 28a-f show d at once.	ecto	MD 10e. Street and Number		Baltimo	10f. Zip (Code		10g. Citizen of What	Country?	
3a or 3	Dir	123 West 29th Str	eet		21	.218		U.S.A.		
5-0036 led within 72 hours after death with the Maryland alygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?			t of Hispanic Origin Cuban, Mexican, Pi		o- 14. Race - A White, e	American Indian, Black, atc.	
P 58		3 Widowed 4 X Divorced	1 Yes 2 X No	1	Yes 2	No specify:		Specify:	White	
ours af ntural	d by	15. Decedent's Education (Specify on	or Dates:	16a. Deced	ent's Usual C	ccupation (Give kind		16b. Kind of Busin		
6 1 72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during	most of work	ing life. DO NOT use	e retired)			
.003 withii giene.	mo	17. Father's Name (First, Middle, Last)		Pr	inter	18 Mother's N	lame (First, Middle,		al Printing	
	Be C		Ruby			Thelm		Mvers		
D 2121 should be fill and Mental It is marked	JO.	19a. Informant's Name/Relationship (Ty		19b. Mail	ing Address	(Street and Numbe	r or Rural Route Nu	mber, City or Town,	State, Zip Code)	
imore, MD 2121 Pages I and 2 should be fi nent of Health and Mental rant: If item 27 is marked or other traumatic event,		Thelma Lee Roetto						ick, MD 2		
MOFe, Pages 1 au nent of He nnt: Kite		1 Burial 2 Cremation 3		Place of Disp crematory or		e of cemetery,	Date	20c. Location - Ci	ty or Town, State	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is mingry or other traumatic.	-	4 X Donation 5 Other Specify: 21. Signature of Funeral Service Licens	200	Anatony	Gifts R				Maryland	
Balti permit. Departur Imports		S A THE STATE OF T					-	Gifts Regi P, Hanove	_	
Physician	_	23a. Part I. Enter the disease, or complifailure. List only one cause on each		th. Do not enter	the mode of	dying, such as card	iac or respiratory an	rest, shock, or heart	Aporoximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (Final disease a.	Schizophrenia	comp1:	icated	by Hypot	hermia		Death	
		b	Due to (or as a consequence	of):						
	miner	Sequentially list conditions,	Due to (or as a consequence	of):						
	Gami	(Disease or injury that initiated C.	Due to (or as a consequence	of):						
760, icate be executed physician and the burial - transit	al Exa	d	22	TT 07) O C		00 1 0 10			
60, ate be executed oblysician and reburial - transi	Medical	X UNPENDED	AMENDED 23a,pt.	11,2/,	∠8a–r, _]	per me,gy	23 1-9-12			
876 tificate ng phy as the b		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		etal death	3 Ectopic pr	egnancy	23d. Date of de Month	livery Day Year	
Box 687 e death certific the attending p	Physician/	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of o	tooth =	Other (Specif				·	
P.O. Bc that the deen ned by the sidetached for	F S	Part ii. Other significant conditions	9 Unknown	resulting in the	underlying o	ause given in Part I	23e. Did t	obacco use contribu	te to the cause of death?	
F. P.O.	<u>a</u>	Atherosclerotic				auto giron iii i uit ii			Probably 4 🗸 Unknown	
of Vital Records, ng Physician: The law require this certificate has been simeral director, page 2 should be	Completed		·	24a. Was		re autopsy findings available r to completion of cause of				
Reco The law icate has	duo							rmed? dea		
Vital Reyssician: The his certificate director, page	BeC	25. Was case referred to medical			26	Place of Death (Ch	-			
Pysic Physic r this o	10	examiner? 1 ✓ Yes 2 No	Residence 6	Other: Scene						
in of iding Ph. h.: After t	ii.	27. Manner of Death 1 Natural 5 Pending	28a, Date of Injury (Month, Day,Year)	28b. Time o		c. Injury at Work?		how injury occurred to to cold	environmental	
Division tal or Attendiu rs after death. al Director: A	ficat	2 X Accident Investigatio	28e Place of Injury - At i	fd07:	20		ltempera	ture		
Div pital or ours aff	Certification:	3 Suicide 6 Could not by determined		king Lo	t		Baltimo	State) 515 Wes	or Rural Route Number, City St 29th St.	
Division of Vital Records, P.O. Box 687 To the Bospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the control of the co		10110011011	n: To the best of my knowle							
To th within To th	Medical	2 0 111011011	On the basis of examination and manner stated.	and/or investig		License number	ed at the time, date		(Month, Day, Year)	
		(101 , 20 8	LADDON			O.C.M.E.		December 9,		
	ŀ	30. Name and address of person who completed cause of death (Item 23a)								
		Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
St Regist	ate	31. Date filed (Month Day, Year) 20	32. Rigistrar's Signa	ture	arles					
			1	1-11						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:32 AM CHARLES RIGGEN DECEMBER 6 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number July 25,1920 402-22-8464 Kentucky Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1XXYes 2 □ No Director MD N/A Baltimore City 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 7518 Riddle Avenue 21224 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [∑Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No ð Specify: 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Goddard Space Ctr 12 Years 4 Years <u>Aerospace Engineer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clifton Riggen Vernal Mattingly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1106 Presa Place Lady Lake, FL Mr. Leo J. Bowers (Brother In Law) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State 12/14/2011 Brookville, Kentucky 4 ☐ Donation 5 ☐ Other (Specify) Triumph Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service 10 Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final PHAG MYOCARDIAL INFARCTION , PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): 4 MONTHS DUSPHAGIA UROSEPSIS OROPHARANGEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner STROKE HYPERTENSION, DIABITES Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes RETENTION, HYPERLIPEDEMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 T Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed sician and burial-tran attending physician the the been signed by page 2 should or Attending Physician: the funeral director, this After s ar er death. filled in by

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

the Medical

should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I matural", or items 23a or 28a-f show i marked other than "natural", or items 23a or 28a-f show

Is marked

Health tem 27 I

permit. Pages 1 al Department of Hee Important: If Item any Injury or othe once.

Physician

/Medical

Examiner

29a. Certifier Medical (check only one)

4 - Homicide

1 = 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0071885

29b. Signature and title of certifier

MULL , MD

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARWAHA MONICA

4940 Eastern Avenue, Baltimore, MD, 21224

DECEMBER 6 2011

Registrar

within 24 hours a

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40319 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:00 p ^M Neil Edwin Rambo December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sex Country) 111inois (Month, Day, Yea Months Days Hours Min Director 332-36-0610 68 1943 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State be notified at Funeral Director 1 Yes 2 No Maryland Harford Abingdon 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō "natural", or items 23a 21009 USA 4114 East Baker Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 14. Race - American Indian Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Flora Lucille Noakes Harold Edwin Rambo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4114 East Baker Avenue, Abingdon, MD 21009 Carol R. Rambo / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial/ 2 X Cremation 3 ☐ Removal from Towson, Maryland 4 Donation 5 Donation (Specify) Hilltop Service Corp. 12-17-11 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, of Funeral 21, Signa Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Li retail 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director, After this certificate has been signed to completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The certifying risposari. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title fi certifier ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLUMTREE TROAD Angel 32. Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DOZIVISKI 3 Physician/ Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death Examiner 4c. County of Death HIVLEST HOSPITAL RANDALLETONA BALTIMOR 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) California **Funeral** 7. Age (In vrs. last birthday Mir 1 M 2 D F **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/A Baltimore City Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ntal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be I Funeral 1607 Harden Court 21230 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married '71 '82 Maryland 21215-0036 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Service Industry is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Clara Leimbach Edward L. Reisinger, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 si ment of Health a 297 Hazel Avenue, Halethorpe, Maryland 21227 Henry Reisinger/Brother other Baltimore, Important: If iten any injury or 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Metro Crematory Inc 12/15/2011 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complic ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to for as a consequence of that the death certificate be executed Cause (Disease or iinjury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): ng physician as the burial Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 1 Yes 2 No the g Unknown P.O. þ signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown been signated by should by Completed 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autopsy certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this n 24 hours after death.

• Funeral Director: After th

pleted filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted . Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2.

To the F
complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25

Registrar
DHMH 17 Rev 7/2009

State

30. Name and

31. Date filed (Month, Day, Year)

au

address of person who completed cause of death (Item 23a) (Typ

32. Registrar's Signature

RUKOWI

Registrar DHMH 17 Rev 1/2001

State

P

29b. Signature and title of contifier MARIO

31. Date filed (Month, Day, Year)

DEC 1 6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANIO A KISENBERGEN 1650 ORLEANS ST IM-SI BAYITIONE,

32. Registrar's Signature

29c. License number

D28768

29d. Date signed (Month, Day, Year)

MD 21231-1000

11-09195	
Milton Spriggs	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

opiiggs		1- For State Climaryiand / Department Certifications	te of Death	Reg. No. 2011 403							
Physicia al Examir		1. Decedent's Name (First, Middle Last) Milton Spriggs		2. Date of Death Month Day Pear December 6, 2011 3. Time of Death 2118 hrs							
		4a. Facility Name (if not institution, give street and number) 1629 Burnwood Avenue	4b. City, Town, or Location of Dea Baltimore								
uneral irector		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Alay) If Under 1 Year If Under 24H Months Days Hours M	1e:							
show any ice.	7	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location Baltimore	10d. Inside City Limit							
h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	1629 Burnward Ave.	10f. Zip Code 24239	10g. Citizen of What Country?							
or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 Poslive Year or Date:	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No specify:								
nt of Health and Mental Hygiene. tt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed b	15. Decedent's Education (Specify only highest grade completed) 16a. De	cedent's Usual Occupation (Give kind or ring most of working life. DO NOT use re Laborer								
Mental Hygiene. marked other than c event, the Medical	8	17. Father's Name (First, Middle, Last) Milton Spriggs	Norma	ne (First, Middle, Maiden Surname) Robinson							
of Health and Me If item 27 is ma	٩	Sandra Spriggs-wife 16	Mailing Address (Street and Number or Bunwood A	Rural Route Number, City or Town, State, Zip Code) 2123 We. Baffiner Maryla 1 Date 20c, Location - City or Town, State							
Department of He Important: If its injury or other t		1 Burial 2 Cremation 3 Removal from State crematory	or other place) n Park Cem. 12	13/11 Baltimore Mayland Faught C. Greene, Fineral, Sen							
ician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not e	Annual Address of Facility YORK ROAD anter the mode of dying, such es cardiac	e Baltimore, Maryland 2132							
niner		. failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Ather Due to (or as a consequence of):	osclerotic Cardiov	ascular Disease Between Onset and Death							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause	ji-								
und transit	I Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.									
ysician a burial -	ledical		ne,g924 2-23-12 sm	Lord Pate of delivery							
	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregr Other (Specify)	23d. Date of delivery nancy Month Day Year							
igned by the	ক্র	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part 1.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Completed			24a. Was an autopsy performed? 1 ✓ Yes 2 No 124b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No							
certific ector, p	Bec	25. Was case referred to medical examiner? Hospital: 4 leastings 2 FR/Out	26.Place of Death (Check	k only one)							
After this meral dir	의	1 Ves 2 No Inspired 1 Inpatient 2 ER/Outp 27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Tim	atient 3 DOA Other Nurs ne of Injury 28c. Injury at Work?	ing Home 5 Residence 6 ✔ Other: Scene 28d. Describe how injury occurred							
24 hours after death. Funeral Director: //etely filled in by the fi	Certification:	1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cit									
within 24 hours after death To the Funeral Director: completely filled in by the	ledical Cer	4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To the comple	Medi	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							
,		M	O.C.M.E.	December 7, 2011							
D		30. Name and address of person who completed cause of death (Item 23á) Russell Alexander MD. Assistant Medical Examiner	900 W. Baltimore Street, Baltin	more, MD 21223							
Sta		31. Date filed (Month Day Year) 32. Registrary Signature	A. C.	OCME							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death DECEMBER Physician/ 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min Months Hours 69 PENNSYCVANIA **Director** Yrs. 28a-f show 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 0 UNITED STAT items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) AMTRAK Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 19a. Informant's Name/Relationship (Type, SANORA SCARCUS) Department of Health ar Important: If item 27 is any injury or other trat 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility (1, 924 YOKK)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2111 Approximate Interval Between nset and Death Immediate Cause (Final TASTATIC Physician/ LUNG CANCOR VORTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy perform certificate To the Hospital or Attending Physician: Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Beath 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After of completely filled in by the funer iniury 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 haples STRET BALTIMOROMO 21264 670

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of D Cynthia Clayton Schafer Physician/ December 11,2011 3:50 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Glen Arm Glen Meadows If Under 1 Year | If Under 24 Hrs . Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Days Jan. 20, 163-32-9366 73 Pennsylvania Director °1938 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore Glen Arm MD1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a (must be 21057 11630 Glen Arm Road USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black White etc. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give white "natural", 3 XWidowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Town Library the Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Lind Clayton, Jr 27 is marker traumatic Annabelle Kennedy Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Mann-daughter 14308 Phoenix Road-Phoenix, Maryland 21131 or other 20a. Method of Disposition Department of H Important: If ite any injury or otl 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery crematory or other place)

Evans Funeral Chapel

and Cremat Di Ser Belair 1 Burial 2 Kremation 3 Removal from State Dec. 13, 2011 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Service
8800 Harford Road-Parkville, Maryland 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ ta disease or condition month Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No npleted filled in by the funeral director, 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 44 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗀 😽 o ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1. Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Sig ature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 CHARLE 51 31. Date filed (Mohita Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40326 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 ecember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death A timore Age (In yrs. last birthday) **Funeral** Social Security Number Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Director 1**X** M 2 □ F 53 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Yes 2 🗆 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA be filed within 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Examiner Armed Forces?.
1 ☐ Yes 2 🗓 No Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give "natural" Specify: 3 X Widowed 4 □ Divorced Year or Dates. nt of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/ladustr (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Barber Shop Elementary/Secondary (0-12) College (1-4 or 5+) ecious OUL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည cobertson 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains O Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State 22/2011 4 ☐ Dopation 5 ☐ Other (Specify) GYNNOAK 21. Signature of Funeral Service License East 1101 E. North Ave. 22. Name and Address Facility Maryland Enter the disease, or complications that caused the death or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Im edi e Cause (Final di ease or condition re un ng in death) Ph_sician/ METASTATI Medical Due to (or as a consequence of) Examiner Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Day the g Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: ပ 1 🗌 Yes this (1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending s after death.

I Director: Aft Accident М 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per PHY G922/16/2011JH Department of Health and Mental Hygiene
-19-12 yt
- Certificate of Death Reg. No. 1- For amend item Registrar 10 2 Date of Death 1. Decedent's Name (First, Middle, Last) Horace Sims **Physician** αu /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Catonsville Genesis Health Care Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Min. 1**∑** M 2□ F Yrs. 01 07 218-26-6573 Director 80 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Examiner must be notified at once. 1 XYes 2 □ No Baltimore Director NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21207 4501 Kathland Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Corp Bethlehem Truck Driver 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bera Wax Horace Sims Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3800 Rivers Ave, Unit 6101, North Charleston Arnetti Sims-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/19/2011 Baltimore, On-Site March F/H West 21. Signature of Funeral Service Licenses tale 4300 Wabash Ave, Baltimore, Md 21215 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final month [¬]hysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown יכמנט nas been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of Day, State 16 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40328 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death [□]ĝ^y, Physician/ December 2011 1:10 P M Robert Dorsey Saunders, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe Age (In yrs. last birthday) **Funeral** Days 230-56-1423 1 🛛 M 2 🗆 F **Director** 70 Yrs. April 24, 1941 Virginia Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13105 Chestnut Oak Drive 20878 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give White Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Physicist Δ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Dorsey Saunders Acquilla Darley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 Alice K. Saunders/Wife 13105 Chestnut Oak Drive, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 15, 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium 2011 Bethesda, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Rockville, Inc. Willia M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between 8 Months Immediate Cause (Final Hepatocellular Carcinoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ cate has been signed by the atter page 2 should be detached for u in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital 1 ☐ Yes 2 X No မ 1 X Inpatient 2 ER/Outpatient 3 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 27. Manner of Deatl 28b. Time of 28d Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 3 = only one) 29b. Signature and title of certifi-29c. License number 29d. Date signed (Month, Day, Year) December 10, 2011 D0061083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Paul Thambi, M.D.

31. Date filed (Month, Day, Year)

9707 Medical Center Drive, Rockville, Maryland

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Day 0, 2011 Physician/ 0800 Estella L. Snyder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 422 S. Durham Street **Paltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 68 03/06/1943 Tennessee 216-42-8727 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 XYes 2 ☐ No Baltimore Maryland N/A 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral United States 21231 422 S. Durham Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status ural", or iter I Examiner Armed Force Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 X No Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: "natural", White 3 Divorced 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry permit. Page 1 and 2 should be filed within 72 r Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Esther Broyles Lillian UNK. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Maderia Street Paltimore, Maryland 21231 Debra Snyder - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/14/2011 Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service Licensee 23a Part 1. Enter the disease shock, or heart failure. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ran.c disease or condition 165tructure Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physiciar Physician/Medical Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No ò Year Month Other (specify) Pregnant at time of death signed by the a d be detached fo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed? Yes 2 No 1 Yes 2 No certificate **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work?
1 Yes 2 No 5 Pending iniurv 1 Natural 24 hours after death Funeral Director: A Accident Investigation within 24 hours after death To the Funeral Director: / completed filled in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 🛎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD 10057237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caroline St. Baltmore

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TAYLOR DECEMBER 1:40 P M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7301 PACELLA COURT CLINTON PRINCE GEORGE'S Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗓 F Days Hours Min JULY 29 Months **Director** Yrs WASHINGTON, DC 578-74-0344 58 Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 🗆 No MD PRINCE GEORGE'S CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7301 PACELLA COURT 20735 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: SpecifyAFRICAN AMERICAN Completed 3 Widowed 4 Divorced mit. Page 1 and 2 should be filed within 72 hours authent of Health and Mental Hygiene. obstant! If fem 27 is marked other than "natur injury or other traumatic event, the Medical E. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CUSTOMER SERVICE REP. <u>GOVERNMENT</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LEONARD FICKLING FRANCES PERKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES T. TAYLOR/DGT. 8733 CONTEE ROAD #203 LAUREL, MARYLAND 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 12/17/2011 LANDOVER, MARYLAND 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility Reene 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart ailure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ CANCER OF PANCREAS Medical resulting in death) Examiner CANCER METASTATIC LIVER Sequentially list conditions, if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir CANCER METASTATIC LUNG burial-tran and Due to (or as a consequence of nding physician use as the burial CANCER METASTATIC BONE Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death asn 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No þ Pregnant at time of death Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CORONARY ARTERY DISEASE Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES MELLITUS page 2 autopsy the Hospital or Attending Physician: The Ishin 24 hours after death.
the Funeral Director: After this certificate h performe Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Tes Other: မ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28h Time of Injury at 28d. Describe how injury occurred 5 Pending injury 1 Tes 2 \square No ☐ Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and t 29c. License numbe

7/8m

State 31. Date filed (Month, Day, Year)
Registrar DEC 1 6 2011

32. Registrar's Signature

of person who completed cause of death (tem 23a) (Type, Print)
E. REID M.D. 1221 MERCANTILE LANE LARGO, MARYLAND 20774

D70922

DECEMBER 15, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Rodney Charles Travers 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 8, 2011 0842 hrs narles Kodne Medical Examiner ravers 4a. Facility Name (if not institution, give street and humber) 4b. City, Town, or Location of Death 4c. County of Death 201 North Washington St Apt 507 **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State or **Funeral** oreian Min. Months Days Hours Director 61 Country) 1 M Marylan 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location uny 1 Yes 2 No 28a-f show Maryland Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Headul and Mental Hygiene.
Importment: If item 27 is marked other than "matural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Washingto 201 Funeral 14. Race - American Indian, 8lack 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Armed Forces? 2 Yes If Yes, Give Year or Dates: 1 Yes 2 No specify: 4 Divorced 3 Widowed <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gordon Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 (22) Diveral (rassing Croodwin 20a. Method of Disposition 20b. Place of Disposition (Nameto) crematory or other place) Cremation 1 Burial 2 3 Removal from State Catorsville Maryland Cremator Metro 22. Name and Address Facility 21. Signature of Funer ervice Licens Eune 1 Baltimore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Sa UNPENDED AMENDED e attending physician for use as the burial Physician/Medi Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Day Live birth Fetal death 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ned by the detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b ≥ 1 Yes 2 V No 3 Probably 4 Unknown Completed has been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autoosy death? performed' this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 2 1 🗸 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No hours after death. Director: Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) within 24 hours a

To the Funeral I determined Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number December 9, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Donna M. Vincenti, MD

DHMH 17 Rev 1/2001 **OCME 2006**

State Registra

31. Date filed (Month, Day, Year)

OCME

11-09346 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Janet Elizabeth Tennekoon 2011 40332 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 12, 2011 0755 hrs **Medical Examiner** Elizabeth Tennekoon Janet 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lutherville **Baltimore County** 900' south of 400 Block of Seminary Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Hours Director 02/27/1945 Country) England 1 M 2 X F 218-60-7832 66 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Lutherville MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 14 Nightingale Way, Apt. B2 United Kingdom Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes If Yes, Give Year 3 Widowed 4 X Divorced 1 Yes 2 X No specify: Specify: White 2 r Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Wine Sales 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B Harold Mabe 1 Willis Elev ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Church End, Great Dunmow, Essex CM 6 2AF, England Geoffrey Eley / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Pages
Department of
Important: 1 Anatomy Gifts Registry12/14/2011 Hanover, Maryland 4 X Donation 5 Other Specify: 5 22. Name and Address of Facility 21. Signature of Frineral Service Licens Anatomy Gifts Registry Connelley Dr., Ste. P, Hanover, MD 21076 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the disease Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease Łxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit sician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Live birth past 12 months? Pregnant at time of death 5 Other (Specify cate has been signed by the att page 2 should be detached for 1 Yes 2 V No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 🗸 Other; Scene Inpatient 2 ER/Outpatient 3 1 Yes

Division of Vital Records, P.O. Box 68760, After this the funeral death. To the Funeral Director: filled in by

28a. Date of Injury FOUND: FOUND: 1 Natural 1 Yes 2 ✔ No 5 Pending Dec 12, 2011 0734 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be or Town, State) 900' south of 400 Block of Seminary Ave, Lutherville, MD determined (Specify) Railroad Tracks Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 13, 2011 O.C.M.E.

28b. Time of Injury

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Donna M. Vincenti, MD

OOME

900 W. Baltimore Street, Baltimore, MD 21223

28c. Injury at Work?

28d. Describe how injury occurred

Subject purposefully laid in path of oncoming

Year

31. Date filed (Month, Day, Year) State 16 Registrar

27. Manner of Death

Certification:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** SSOWSKI Edwin December 12 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours **Funeral** 1 🛛 M 2 🗆 F California 1953 18, 58 213-60-6108 **Director** Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 X No Director event, the Medical Examiner must be notified MD Carroll Finksburg 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numbe ò USA 21048 2210 Yellow Pine Drive items 23a death Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ⅓ If Yes, Give Year or Dates: be filed within 72 hours after 1 Never Married 2X Married 2**X** No 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 ö Specify. Specify: White ģ 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than **HVAC** Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Mildred Lund Joseph Robinson Schafer Tyssowski, Sr is marked Pages 1 and 2 should nent of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2210 Yellow Pine Drive Finksburg, MD 21048 Carol Grenier Tyssowski/wife permit. Pages 1 and 2.8 Department of Health ar Important: If item 27 is any injury or other trauonce. 20c. Location - City or Town, State 20a. Method of Disposition
1 Burial 2X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Final Journey Crematory 12/17/11 | Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 23a. Part 1. Enter the dispase, or complications that caused the shock, or heart failure. List only one cause on each line. MD 21029 MO1251 Beverly L. Heckrotte, P.A. Clarksville, Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** SCHEMIA BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami DISSECTION The law requires that the death certificate be executed AORTIC physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death signed by the att 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes 2 📝 2 | No certificate 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other: Hospital: 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 No 2 ER/Outpatient 1 Yes Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation Injury 1 Natural 1 Yes 2 No М death. 2 Accident I Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office 4 - Homicide building, etc. (Specify) 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 00 72 738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Bo Kim park 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 6 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 6:10 P.M Joseph Wilson Utz December 2011 . Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Manchester Long View Nursing Home If Under 1 Year | If Under 24 Hrs.

Months Davs Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex 1.XXM 2 □ F Funeral Feb. 10, Year) 1936 Maryland Days 75 Yrs Director 218-32-6195 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10a. State 10b. County Director 1XXYes 2 ☐ No Manchester Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21102 3332 Main Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1XXNever Married 2 ☐ Married ģ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Master Power Maintenance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Helen Mae Utz Herbert Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1340 West St., Hampstead, MD 21074 Barbara Thomas (Friend) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State 12/19/2011 Greenmount Ch. Cem. Greenmount, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si etur of Funda solice Lice 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr., Manchester, MD 21102 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Pnysician/ wecks Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day signed by the atte Pregnant at time of death 5 Other (specify) ☐ Yes ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown plnods 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has funeral director, page 2 ? performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) by the funeral director, Be Other: 1 🗌 Yes 2 17 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 Natural 5 Pending 1 Yes 2 No 124 hours after death.

e Funeral Director: A pleted filled in by the fu Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed 2 [3 [(Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who complet

1 6 2011

31. Date filed (Month, Day, Year)

Spell

of death (Item 23a) (Type, Print)

caus

2827

32. Registrar's Signature

737573

MD

21209

15,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Zon 543 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ha omwell If Under 1 8. Date of Birth 9. Birthplace (State or Foreign Security Numbe 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F 87 Months Hours Min. (Month, Day, Year, 217-18-4808 Director ΜD Dec Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits event, the Medical Examiner must be notified at MD Baltimore 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1111 Bunbury Way 21205 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 0 6 1 Never Married 2 Married Yes 2 X No White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural" Completed 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Social Security Elementary/Seconday (0-12) College (1-4 or 5+) 12th Supervisor Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked oil any injuy or other traumatic even once. 2 Maude Ester Wilson Henry Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7813 Penny Road Nottingham MD Larry Wilson /son 21236 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Garrison Forest 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/14/11 Ownings Mills MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly funeral Home of Essex 21221 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea shock, or heart failure. Li only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a co Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ias been signed by the i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No s after dea... *al Director: After *v the fi 1 X Natural injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Franciscus: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as alared. (Check within 2 29b. Signatur 29d. Date signed (Month. Day, Year) n**t** 23a) (Type, 31. Date filed (Month Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40336 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CLYDE VERNON WILHELM, JR. 9:34P 2011 Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FRANKLIN SQUARE HOSPITAL ROSEDALE Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Jan. 26,1943 Days Hours Min Maryland 214-40-0223 **Director** 1 □XM 2 □ F 68 Yrs. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Yes 2xxNo Baltimore County Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 21234 USA 3302 Glenside Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2XX Married "natural", or þ 1X Yes 2. No If Yes, Giv**√1.et⊓am** Year or Dates. 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Police Dept. AA Degree Detective Sqt. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Caroline Hilgeman Clyde Vernon Wilhelm, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Wilhelm (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XIX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 12-19-2011 Baltimore, Md. Sg at re of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home, Inc. Cotha 7401 Belair Rd. Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a ACUTE MYOCARDIAL INFARCTION 3<u>0 min</u> disease or condition Medical resulting in death) **Examiner** ARTERIOSCLEROTIC HEART DISEASE 14 Yrs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine sician and burial-transit Due to (or as a consequence of) resulting in death) Last physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Type 2 Diabetes Mellitus 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a, Was an cate has by page 2 s autopsy performed? Yes 2 🛣 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 🔀 No ပ္ 1 Inpatient 2 🙀 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ₃ 🗀 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) M.D. D0017728 2011 December 14, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8022 Belair Road Ba Yin Oung, M.D. Baltimore, Maryland 21236 31. Date filed (Mortif, Day, Year)

Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40337 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 6:40A M 12-15-2011 <u>Madeline Doris Wiley</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Stella Maris Timonium 8. Date of Birth (Month, Day, Year 1–28–1930 If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 212-26-7769 Maryland **Director** 1 □ M 2**X** F 28a-f show or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Perry Hall 1 Yes 2 No Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 USA 9507 Kingscroft Terr, Unit F 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 🔀 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working | Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government dministrative Asst. and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ျ Genevieve Bitzelberger Bernard Trageser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry Hall, Md. 21118 Unit F 9507 Kingscroft Terr. Spouse Francis Wiley 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State SacredHeart of Jesus 12-19-2011 Dundalk, Md. 4 Departion 5 Other (Specify) Signalur 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Road Nottingham, Md, .21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physicia ... END STAGE PARKINSON'S DISEASE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death ed by the at detached f s been signed k should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has performed? Yes 2**X** No this certificate Division of Vital in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \boldsymbol{X} Other (Specify) **HOSPICE** 2 X No မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 124 hours after death. e Funeral Director; Aft eletely filled in by the fur 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NS071 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DECEMBER 15,

MADELINE WILEY

State Registrar

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY RD.

CRNP

32. Registrar's Signature

TRACIE L. MORGAN.

DEC 1 6 2011

MD 21093

TIMONIUM,

11-09222						
Vaudrie Wood						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

December Name First Mode Last	audrie Wood		State of N 1- For State Registrar	Maryland / Departm <i>Certific</i>	nent of cate of		Mental Hy	-	eg. No. 20	11 403
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Mary Land								-	Fo	
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Deet Creek Unit Certification 5 Other Specify. 22 Name and Address of Facility McComas Funceral Hone, P. A. Sqraphyre-forused Serves to compilations but caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, shock, or heart immediate Clause (final disease). 23 Part I pert in disease, or compilations but caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, shock, or heart immediate Clause (final disease). 24 Part I pert in disease, or compilations but caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, shock, or heart immediate Clause (final disease). 25 Part I pert in disease, or compilations but caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, shock, or heart immediate Clause (final disease). 26 Part I pert in disease, or compilations but caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, shock, or heart immediate Clause (final disease). 27 Part I pert in disease, or compilations but caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, shock, or heart immediate Clause (final disease). 28 Part I pert in disease, or compilations but caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, shock, or heart immediate Clause (final disease). 28 Part I pert in disease, or compilations but caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, shock, or heart immediate Clause (final disease). 29 Part I pert in disease, or compilations but caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, shock, or heart immediate Clause (final disease). 29 Part I pert in disease, or compilations and caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas, shock, or heart immediate Clause (final disease). 20 Part I pert in disease (final disease). 20 Part I pert in disease, or compi	10re, ages I an nt of Heal t: If iten other tra		1 X Burial 2 Cremation 3 R	temoval from State crema	atory or other	er place)				
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30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	- = = = = = = = = = = = = = = = = = = =	₩								
OCME Mary G/ Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			30. Name and add/ess of person who compl	leted cause of death (Item 23a))		I.E.		December 8, 2	2011
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State 31. Date filed (Month, Day, Year) Registrar 12. Registrar's Signifure			31. Date filed (Month, Day, Year)	2. Registrar's Signature	park					

State of Maryland / Department of Health and Mental Hygiene 40339 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ WAHL 0105AM REM DECEMBER 10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day Year) John Hopkins Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 73 Hours Min 220-36-2533 1938 Maryland **Director** 1 X M 2 □ F Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? ns 23a c c must h be Funeral 21202 United States 1101 St. Paul Street Apt. 1710 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iten edical Examiner Was Decedent Ever In U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 1958 - 59 Black White etc. þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Framer Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of ဂ Orem Howard Wahl Elizabeth Katherine Wick Page 1 and 2 should then tof Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Otts Munderloh /Friend 9895 Palace Hall Drive # 202 Laurel, MD 20723 27 Department of Health Important: If item 2 any injury or other t other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec 13 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Dense 22. NaOremaddeen Fand Funeral Alternatives Relacca Hacker 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 1) iscase disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à The law requires 1 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No filled in by the funeral director, page 2 this certificate Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation hin 24 hours after death the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 3 29b. Signature and title of certific 29c. License number 29d, Date signed (Month, Day, Year) RES-000 ZOIL 10, December 12+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael verma 31. Date filed (Month, Day, 32. Registrar's Signature 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40340 State of Maryland / Department of Health and Mental Hygiene 20 | | for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ Marion AliceWard December 16:49 M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death St Agres Hospital Baltimore Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** (Month, Day, 1 M 2 TF Months Hours Min. New Jersey 220-36-5722 69 1942 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Baltimore City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1009 Veronica Ave. 21225 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ρ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Black Specify: Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Package Sorter Clothing Donation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 27 is marked or traumatic e Winstead Ella Mae Cooper permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Kelly / Daughter 6117 Little Foxes Run, Columbia, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4

▼ Donation 5 ☐ Other (Specify) Uniformed Sers. Univ. 12/14/2011 Bethesda, MD System of Fundal Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services 20910 Ave. Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Cancer Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner diseare year s runa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine jean To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last oronaru Due to (or as a cons - nce of) Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ↓ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has be irector, page 2 s autopsy performed? 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-No 1 🗌 Yes ၉ 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H lains C.M lint P2406 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11/ AING TINT 000 Codor Ave, Baltimore, MD 21229 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40341 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician <u>5:40</u> A[™] Jacqueline Woerner 2011 December 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manchester Carroll Long View Nursing Home 8. Date of Birth (Month, Day, Year) Feb 20, 1926 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 😾 F Months Hours Min. 85 216-20-9492 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Carrol1 Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1211 North Main Street, #201 United States 21074 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, GiveX Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. 2 Specify: 3√2 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Office Work Montgomery Ward 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic ev Louis R. Aaron Laura Windisheim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon Schisler/Daughter Box 324, Manchester, Maryland 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 12/15/2011 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a_consequence of): Examiner mys Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner (or as a consequence of) Exami extension and burial-trar Due to (br as a consequence of): Box 68760 the attending physician ched for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown 9 Unknown signed by t ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Director: After that in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours aff

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) **DEC 1** 6 2011

29c. License number

Rd.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend 1 per dr. g922 12/16/14 the cate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Male Yi Physician/ Month 2011 0048 M Lunnamo Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MI County General Columbia Howard Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** NIA Months Hours Min. 1 M 2 □ F Director Maryland 0 19/18/11 28a-f show 10a. State with the Maryland 10b. Count 10c. City, Town or Location notified at Director 1 Yes 2X No Montgomery MD Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 23a Funeral 20904 USA 2733 Cornet Court items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married or þ Yes 2 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: asian "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be filed nt of Health and Mental H E: If item 27 is marked ot ၉ Vivian Yi David H. Yi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard County General Hospital 5755 Cedar LaneColumbia,MD Department of He Important: If itemany inition 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician EXTREME disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed and I-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending plant of the season IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death ed by the a 2 No 9 Unknown 9 Unknown signed to d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 ပ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 \square No Accident the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of certi 29d. Date signed (Month, Day, Year) 30. Name and address of perso cause of death (Item 23a) (Type, Print) Posito 31. Date filed (Month, Day, Year 32. Registrar's Signature State 6

Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $201\overset{\text{Year}}{1}$ **Physician** 6:05p.M December Alvin Lee ATKINS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Twin Oaks Assisted Living Williamsport Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 1, 1923 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Virginia 112 M 2□ F 88 223-24-3781 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-1 show eny injury or other traumatic event, the Medical Exemination. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Washington 1 Yes 2 No Maryland Director Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 812 Willow Circle 21740 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ₺ Yes 2 □ No 194 If Yes, Give Year or Dates: 194 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1943 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: white Specify: 1945 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) federal gov't carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry B. Atkins 2 Beulah Judd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Schleigh - nephew 17812 Burnside Avenue, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Memorial December 7, Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenson Minnich Funeral Home 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 Partie X How 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCETE **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that influed events resulting in death) Last Examiner Due to for as a consequence ofk To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed use as the burial-transit ettending physicien end for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the detached been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à CONGESTIVE HEART 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA PIS I After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 Yes 2 No 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAMS N. ARTICAN 154 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 29 Day Physician/ 10:33 P M George Lawrence Altman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5630 Wisconsin Avenue Apt. 807 Chevy Chase Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours July 9. 1919 Illinois 353-10-6761 92 **Director** Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryland rector 1 X Yes 2 No Marvland Montgomery Chevy Chase ۵ 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code ms 23a oi must be Funeral 5630 Wisconsin Avenue Apt. 807 20815 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or item edical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates.1944–1948 Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Medicine Radiologist permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, : Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ David Altman Gertrude Drues 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muriel Joy Altman / Wife 5630 Wisconsin Ave. Apt. 807 Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King David Memorial Gardens Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 5755 Castlewellan Dr. Alexandria, VA 22315 Jefferson Funeral Chapel Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Years Immediate Cause (Final Physician/ Parkinson's Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna5 ☐ Other (specify) in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown been signed by Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Congestive Heart Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Tes 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier December 2, 2011 D0023127 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 5215 Loughboro Rd. NW Washington, D.C. 20016 Kevin Nealon, M.D. 31. Date filed (Month, Day State DEC 0 5 2011 Registrar

Registrar

State

Shahnawaz Khan, M.D

. Registrar's a ignatura

2533 Augustine Herman Hwy. Suite A.

Chesapeake City, MD 21915

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ 2134 PM III James ecemb Medical 4b. City, Town, or Location of Death **Examiner** Facility Name (if not institution, give street and number) 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 221-40-8536 1 **X** M 2 □ F Months Hours Min. (Month, Day, Country 58 Director 03/24/1953 DE Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amorphism of the traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Kent Galena 1 Tes 2 X No 10g. Citizen of What Country? 10e Street and Number 10f Zip Code Funeral 21635 USA 14153 Golts Caldwell Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Heavy Equipment Operator 11 Be 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Burcham 17. Father's Name (First, Middle, Last) 2 Robert Brierley Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Brierley / wife 14153 Golts Caldwell Rd, Galena, MD 21635 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Delaware City Cemetery 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 12/08/2011 Delaware City, DE 4 ☐ Donation 5 ☐ Other (Specify) 22 Strand & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702 Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ myound disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine cause. Enter Underlying executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 A 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 🗆 🚾 1 Tes 1 Inpatient 2 PR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours atter ueau...

To the Funeral Director: After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier NO

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CHH HU

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40347 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elsie Mae Barger Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Reeder's Memorial Home Washington Boonsboro Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Hours Min. May 27 ay, 1921 Director 90 215-74-2793 Middletown, MD Usual Residence of Decedent or 28a-f show 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Frederick Brunswick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 109 West "B" Street 21716 USA and 2 should be filed within 72 hours after death Health and Mental Hygiene. em 27 is marked other than "natural", or items 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George H. Flook Bertha May Blank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 East "D" Street, Brunswick, MD Jo Ann Thompson, Daughter 21716 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Clustered Spires 12/1/11 Frederick, MD Signature of Funeral Seguceticensee 22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ M40 CARDIAC NAMCERON r lin Medical resulting in death) Due to (or as a consequence of): **Examiner** CORAMINY MURRY DISTAN 1 cms Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury DIMBETES 4 KMRS MEMILITUS. attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed? Yes 2 1 2 💆 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ျှ 1 ☐ Yes 2 🔀 No 4 Mursing Home 5 Residence 6 Other (Specify) this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work after death. Director; Af 1 🗌 Yeş 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Nov person who completed cause of death (Item 23a) (Type, Print) and address of 5 gistrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Day 2004 PM M Dec 2011 Helen Elizabeth Barnard Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Somerset 11943 Jeffrey Lane Princess Anne If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗹 Director Virginia 1937 231-50-7110 Nov Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f sho the Me Leal Examiner must be notified at Director 1 Yes 2 No Maryland Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11973 Jeffrey Lane 21853 U.S. should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give 3 Divorced 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. Annie B. Zimmer Robert L. Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11973 Jeffrey Lane, Princess Anne, Md. 21853 Stephen C. Barnard Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/6/2011 Princess Anne, Md. Beechwood Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hinman Funeral Home M00295 21853 11673 Somerset Avenue, Princess Anne, Md.At 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final score Physician/ ease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 as t IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death 5 Other (specify) detached Unknown P.O. 1 as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 2 No Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes 4
Nursing Home ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 2 🗌 No Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3

State

DHMH 17 Rev 7/2009

Registrar

re and title of ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

29b

POBOX1733 SA4SBURY, MD 21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 1014M Delsie P. Beauchamp November Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICIMICO TENINSULA REGIUNAL Medical SAL156414 Date of Birth (Month, Day, Yea 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Hours Maryland **Director** 216-56-1325 88 1923 1 □ M 2 🗹 Aug. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 11094 Harry Riggin Road 21853 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuba 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arch Riggin Ina Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Hodges 1016 Schumaker Woods Road, Salisbury, Md. 21804 Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beechwood Cemetery 12-01-11 Princess Anne, Md. 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Licenses M00295 11673 Somerset Avenue, Princess Anne, Md. 21853 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death ediate Cause (Final Physician/ He sease or condition Medical resulting in death) Due to (or as a consequation of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 2 N Hospital or Attending Physician; 24 hours after death. funeral director, 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner? Other: 2 No မ Notice 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Division Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/28/11 D63199 Name and address of person who completed cause of death (Item 23a) (Type, Print) VO HRA GASTERN SHORE SALISBURY MD 21804 910 DR 31. Date filed (Month, Day, Year) 32, Regetrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Moranber 2011 CAROL SUE CLARK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorcheste ambridge Dorchester General If Under 1 Year If Under 8. Date of Birth Birthplace (State or Foreign Country)
 TOLIA Age (In yrs. last birthday) **Funeral** ^{Year)}1<u>943</u> 1 M 2 X F MARCH 6 68 Director 214-42-8142 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director MD TALBOT ST. MICHAELS 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Completed by Funeral 9199 MARTINGHAM DRIVE 21663 USA . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married 21215-0036 1 Yes 2X No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SECONDARY EDUCATION TEACHER 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IRENE SIEGFRIED KENNETH FURNISH, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROGER E. CLARK, HUSBAND 9199 MARTINGHAM DRIVE, ST. MICHAELS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State CHESAPEAKE CREMATION: 11/29/2011 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBRO VASCULAR ACCIDENT Pnysician/ disease or condition Medical resulting in death) Examiner Examine Physician/Medical Completed by

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 certificate has b lirector, page 2 s

Be

Certificate: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequence of):							
that initiated events resulting in death) Last	Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		topic pregnancy her (specify)		23d. Date of delivery Month Day Year				
Part II. Other significant conditions of	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de							
			1 ☐ Yes 2	2 No 3 Probably 4 PUnknown				
			24a. Was an autopsy performed?					
25. Was case referred to medical examiner?		26. Place of Death (Chec	k only one)					
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 1 And Natural 5 Pending 2 Accident Investigation		28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how inju	iry occurred				
3 Suicide 6 Could not to 4 Homicide determined		factory, office	28f. Location (Street as City or Town, State	n (Street and Number or Rural Route Number, Town, State)				
(Check 2 Medical Exam	rsician: To the best of my knowledge, death occuriner: On the basis of examination and/or investigates Practioner: To the best of my knowledge, death	on, in my opinion, death occurred a	t the time, date and plac	e, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier	29c. License number	29d. D	29d. Date signed (Month, Day, Year)					

D69234

STREET

CAMBRIDGE

3. Time of Death

IOWA

WHITE

21663

Approximate Interval Between Onset and Death

23 , 2011

MARYLAND 21613

10d. Inside City Limits

1 Yes 2 No

1618PM

State

11

MD

egistrar's Signature

503

address of person who completed cause of death (Item 23a) (Type, Print)

ERRABOLU

JEEVAN

31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryana 9 Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 4.00 P Physician/ 27, Lois J. Coats 20 TT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Woodsboro 653 West Adams Circle If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Social Security Number 7. Age (In yrs. last birthday, 364-32-5725 5727 Days (Month, Day, Year) Director 1 □ M 2 🗓 F 80 August 2,1931 Michigan 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Maryland Frederick Woodsboro 1X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Funeral 21798 United States 653 West Adams Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 Divorced Completed er than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ed other than event, the M $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 10 \end{array}$ College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic evenones. ၉ Helen Cape Thomas Theodore Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coats / son 9506 Highlander Blvd./Walkersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem.Garden DEC.1,2011 |Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home re of Funeral Service Lice 1621 Opossumtown Pike/Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia x r respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Vear ed by the a 9 Unknown eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပု 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person w o completed cause of death (Item 23a) (Type, Print) 2/2

DHMH 17 Rev 06-2011

State Registrar gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2011 40352 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:00 A._M November 26, 2011 Cullers Carmenitta Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick St. Joseph's Ministries, Inc Emmitsburg Funeral 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 577 Security Number 1 M 2 XF May 9 Tay 914 West Wirginia 97 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Emmitsburg Maryland Frederick 10f. Zip Code 21727 10e. Street and Number 10g. Citizen of What Country? Funeral 331 S. Seton Drive 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after deat of Health and Mental Hygiene. item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner I 14. Race - American Indian Armed Forces?

1 Yes 2X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
lift. DO NOT use retired)
Voucher Examiner 16b. Kind of Business Industry (Specify only highest grade completed) rould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Banking Be 17. Father's Name (First, Middle, Last) th and Mental F. 18. Mother's Name (First, Middle, Maiden Surname) Flora Moser ပ္ Best Charles 9a. Informant's Name/Relationship (Type, Print) Kathy Bowman/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17 Parkland Court, Gettysburg, PA 17325 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State pernit. Page 1 Department of Important: If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State BD 4 Donation 5 Other (Specify) Arlington, VA Arlington Nat. Cem 21. Signature of Funeral Service Liesnsee 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 a am Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical Hospit or Attending Physician: The law requires that the death certificate be Box 68760 attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been si page 2 should b Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of Certificate: 28c. Injury at work? 1 Natural injury 5 Pending 24 hours after death. Funeral Director: A Accident 1 Yes 2 No Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: T. the basis of my included to other countries of the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 only on 29b. Signatur fitle of certifier 120018705 operson who completed cause of death (Item 23a) (Type, Print)

a rroll 310 S. Seton me and address 0 Emmitsburg an 31. Date filed (Month, Day, Year) 32. He istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

11-09168 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David Oliver Chapman State of Maryland / Department of Health and Mental Hygiene 2011 40353 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day December 5, 2011 Medical Examine 1434 hrs David Oliver Chapman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8460 Crain Highway Upper Marlboro Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country)Maryland Months Days Hours Director 1 M 2 F 213-98-8371 44 04/18/1967 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No Upper Marlboro permit. Pages I and 2 sbould be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien and Status and of Health and Mental Hygien "matural", or items 23a or 28a-fish Important: Hitem 27 is marked other than "matural", or other trawnatic event, the Medical Examiner must be notified at once in jury or other trawnatic event, the Medical Examiner must be notified at once Prince George's Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8460 Crain Highway 20772 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No Yes, Give Yee 3 Widowed 4 Divorced 1 Yes 2 No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Compl 12 HVAC Mechanic, Contractor HVAC 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Spike Mannie Chapman Dorothy Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie D. Fox, Sister 2737 Hambleton Road, Riva, MD 21140 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) St. Barnabas Cemetery 12-12-2011 Upper Marlboro, MD 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. Willio M00715 (Jus 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Immediate Cause (Final disease a Freon Intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Lest transit Physician/Medical AMENDED 23a, 27, 28a-f, per me, g_{923} 1-9-12 sm X UNPENDED ned by the attending physician detached for use as the burial The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be deta <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 1 🗸 Yes 2 No funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 V Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 X No subject inhaled freon 5 Pending fd 12-5-11 fd 02:10 pm 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8460 Crain Hwy Upper Marlboro, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be

Division of Vital

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Homicide

29b. Signature and title of certifier

30. Name and address of person who completed ourse of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year)

(Specify)

and manner stated

32. Registrar's Signature arke a BELAND

Found:Residence

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 6, 2011

State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 40354 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 9:15 AM 2011 12 Thelma Patton Crane /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Kavenwood Lutheran Village Hagerstown 8. Date of Birth (Month, Day Year) Aug. 15,1926 Birthplace (State or Foreign Country)
 Maine If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 2 🗓 F 85 007-22-7468 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, It is in class Examiner must be notified at 1 ☐Yes 2 No Maryland Washington County Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 1183 Luther Dr. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: White 21215-0036 1 ☐ Yes 2 🛛 No 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electronics Mfg. Secretary 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Evelyn LaBossiere Patton Charles E. Patton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. 13002 Cathedral Ave. Hagerstown, MD 21742 Frances P. Gray-siser 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Dec. 3,2011 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 Latten 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it air, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 💆 No 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 21 No 1 Inpatient Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Date of Injury (Month, Day, Year) After 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely

State

hahid Mahmosa 31. Date filed (Month, Day, Year Registrar

29b. Signature and title of certifie



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend #5 Per FH G922 1272/2011 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | | 1 - State Registrar 40355 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:15 Å M Nowember 27, 2014 Physician/ Betty Jean Corya Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Ft. Washington Ft. Washington Hospital \$309~34~5935 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2XXF 09/2341930 Terriessee 305 28 8419 81 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director must be notified Prince George's Camp Springs 1 Ves XX No Maryland 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a USA 20748 6727 Edgemere Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2xx No If Yes, Give Year or Dates. White 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Education Teacher School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kenneth Sill Land 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6727 Edgemere Drive Camp Springs, Maryland 20748 Richard Lee Corya / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State emetery, crematory 02/03/2012 Arlington Nat. Cem. Arlington, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of FacilityGeorge P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Ōxon Hill, Maryland 20745 e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Theroscleratic Onset and Death Immediate Cause (Final Candio Vasular Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for as a consequence of thank heading to in redist cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? been signed by the atte Month Dav Vear Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 2200 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2, XNo Certificate: To 1 Inpatient 2 KER/Outpatient 3 IDOA 24 hours after death. Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation Could not be 6 🗌 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day,

DEC 0

5 2011

SidaRous, MD 1170/ /ivingstar Ro # 101. It washington MD 20766

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month A M 2011 6:40 Edward J. P. Duffy November 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Calvert Prince Frederick Calvert Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-02-1936 5. Social Security Number 7. Age (In yrs. last birthday) Min. Days Hours 1**X** M 2□ F Brooklyn, 75 083-28-2885 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Lusby Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20657 12850 Laurel Way 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 Yes, Give 2 🗆 No 1 Never Married 2 Married 1956 1 □Yes 2 🙀 No White 3 Widowed 4 Divorced 1963 Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) United Airlines Airline Pilot 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kathleen Horan James Duffy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P. O. Box 1548, Lusby, Maryland 20657 Margaret K. Duffy - Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11-28-11 Alexandria, Virginia Rausch Funeral Home, P. A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due f (or as a consequence of); muestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). ardio my Due to (or as a consequence of): yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

permit. Pages 1 and 2 s Dupartment of Health an Important; if item 27 Is any injury or other trausone.

Physician

/Medical

Examiner

10a State

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Director

Funeral

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Physician/Medical

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Eventine must be netfined at

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than '

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

he burialphysician as t attending p signed by the a I be detached f has page

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

this certificate Hospital or Attending Physician: I Director: After to in by the funeral death. after To the Hospital o within 24 hours aff To the Funeral Di completely filled in

IF FEMALE: 23b. Was decedent pregnant in the past 12 months 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an autopsy performed 2 2 No 2 1 No 1 □Yes 1 ☐Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred Injury 1 Vivatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print)

KW 10+1

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12 20 11 4 Donald Isaac Daring 11:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Upper Marlboro 110 Graiden Street If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours **Director** 127-52-6828 1**X** M 2 □ F 11/03/1956 55 Jamaica Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location Director 1 X Yes 2 □ No Maryland Prince Georges Upper Marlboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 110 Graiden Street 20774 U.S.A. hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. the Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married "natural", or 2 Yes 2**X** No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced B1ack 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) System Engineer Information Technology Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Adrian Bereford Daring Cornel Elfreda Addison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Aceituno-Daring/Wife 110 Graiden St. Upper Marlboro, Maryland 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 🎇 Removal from State 4X Donation 5 ☐ Other (Specify) Science Care Colorado 12/21/2011 Aurora, Colorado 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service on see h 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neodasm mallanant vedes disease or condition Medical resulting in death) Due to (or as consequence of) Examiner dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed the burial-tran and Due to (or as a consequence of). physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed? Yes 2 N or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🗌 Yes 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending s after death.

I Director: Aft
ed in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 24 hours after Funeral Dire City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M nounder 025001 12-05-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAY LIPPMAN MO 9200 BASIL C7 STE 200 LARGO JW-0 31. Date filed (Month, Day, Yea State

Registrar

8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 4, 201^{Yea} 11:25 am Beatrix Devol 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Washington Williamsport Homewood Retirement Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month Day Y April 5, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Days Year 1 □ M 2 🔀 F Months 1919 West Virginia April 92 232-05-7920 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Maryland | Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 USA 16505 Virginia Avenue 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Government Executive Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mount Marion Cornelius Knaus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 129 E. Potomac St. Williamsport, MD 21795 Sharon Brown (Daughter) 20c. Location - City or Town, State Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) North Evergreen Cemetery 12-8-11 Parkersburg, W. Virginia 4 □ Donation 5 □ Other (Specify) f Funeral Service Lice 22. Name and Address of Facility Osborne Funeral Home P.A. 21. Signatur 425 S. Conococheague St. Williamsport, MD 21795 236. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCLEROTIC CARDINVASCULOR YRI ARTERIO Due to (or as a consequence of): DISEAJE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Be Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To

Physician

/Medical

Examiner

Director

Funeral

\$

Completed

Be (

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination must be mailed at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

•	d							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Year							
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?						
PERIPHERA	L VASCULLE DISEASE	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow						
NYPERTENS	100 DEEP VEIN THROMS	24a. Was an autopsy performed? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Were autopsy findings available prior to completion of cause of death? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)						
25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 Yes 2 √No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursin	ng Home 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day, Year) 28b. Time of Solution Injury 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	Physician: To the best of my knowledge, death occurred at the time, date and paminer: On the basis of examination and/or investigation, in my opinion, death and manner stated.							

29c. License number D0018019

7W-5 State

VASAUT 31. Date filed (Month, Day, Year)

- LI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

340 Mill 32. Registrar's Signature

12-5.11

mb VALERSTOWN

29d. Date signed (Month, Day, Year)

DECEMBER 5,2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ayne Medical 4a. Facility Name (if not institution, give street and nun 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICA . Date of Birth (Month, Day, Year) If Under Year If Under 9. Birthplace (State or Foreign **Funeral** Days Country) 230-42-5530 Director 1 **Y**M 2 □ F 5-3-1936 28a-f show 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 KYes 2 ☐ No ccomack hincoteague 10g. Citizen of What Country? 5 10e. Street and Number items 23a Funeral 3331 12000 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 S No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 Yes 2 No "natural" Completed 3 ₩Widowed 4 Divorced Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Jaterman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and item 27 is n hincotengue, VA a 20c. Location - City or Town, State Marvin John 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State 1-25-11 Chincoteague, VA Cemeter 4 Donation 5 Other (Specify) Chincoteague, VA 23336 Signature of Funeral Service Licensee 22. Name and Address of Facility Botto Church Home 1 TUNE POR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown ed by the a detached f 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy perform 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ဂ္ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work?
1 Yes 2 No Investigation Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely only one 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Man) Registrar's Signa State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40360 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 10, HARRY GRIFFITH DAVIS 2011 4:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Safe Haven Manor Sudlersville Queen Anne's If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days OCT 27 Hours Min. 1 X M 2 □ F Maryland 90 **Director** 218-16-6430 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Bright file in 21 is marked other than "nature."

any injury or other trained. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD 1 🗌 Yes 2 🔀 No Kent Galena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 31940 Virginia Ave. U.S.A. 21635 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Olin Staats Davis, Sr. Mary Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olin S. Davis, Jr. (brother) 34002 Sassafras Caldwell Rd. Galena, MD. 21635 20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stephen's Cemetery 12/17/11 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Docation 5 Other (Specify) Earleville, MD. 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 M00510 Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physici_n ROFOGNA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Lynphom Sequentially list conditions, if any, saiding to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transi Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? trantensen Yes 2 No 1 Yes 2 No 25. Was e referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🖗 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) CARE Hours 1 Tes

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

30. Name after address of person who completed cause of death (Item 23a) (Type, Print) John C. Arrabal, M.D.

31. Date filed (Month, Day, Year) 6 2011

223 High St. 32. Registrar's ignatur

State

Registrar

Chestertown,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ **EDWARD** DOVE ARTHUR DEC 2011 7:24A Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** CHARLES 1011 COPLEY AVENUE WALDORF If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days **Director** 577-48-3715 1 ★ M 2 🗆 F NOV.10,1934 MARYLAND 77 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State must be notified at Director 1 Yes 2 No MD CHARLES WALDORF 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number o Funeral items 23a 20602 1011 COPLEY AVENUE U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. o ģ 1 Never Married 2 Married Maryland 21215-0036 nours after 1 ☐ Yes 2 K No Specify Specify: WHITE If Yes, Give "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) MEAT MANAGER DEPT. OF DEFENSE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDWARD LEROY DOVE HAZEL LOUISE CUSICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 slot Health a item 27 i NANCY DOVE/SPOUSE 1011 COPLEY AVENUE WALDORF, MARYLAND 20602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of DECEMBER 20c. Location - City or Town, State of Page 1 1 Burial 2 X Cremation 3 Removal from State = ō METRO . CREMATORY 2, 2011 ALEXANDRIA, VA Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Line 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SUDOEN DESTH Physician/ resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a co that initiated events Due to (or as a consequence of) resulting in death) Last ding physician Physician/Medical P.O. Box 68760 the as IF FEMALE use 8 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day for Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, page 2 should hypelin distribute. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy has with rospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this completely filled in heart. 2 🗀 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28d, Describe how injury occurred Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accider 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35345 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Registra

& WAShington Rd #3010, waldoef

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene REP 1A tate EA Certificate of Death Reg. No. 2011 40362 2. Date of Death 3. Time of Death Physician/ December ¹¹ 2011 9:24 PM Dolores Glendora EYLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Hagers** town Washington 301 Daycotah Avenue If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months (Month, Day, Year) 213-24-9107 83 **Director** 1 🗆 M 2 🗶 F Nov 30, 1928 Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hagerstown MD Washington 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ems 23a or r must be r Funeral Page 1 and 2 should be filed within 72 hours after death with USA 21740 301 Daycotah Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc.
White ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Completed 3 X Widowed 4 Divorced Health and Mental Hygiene. tem 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education 0 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Waldo Faulder Mary Marie Shafer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 Maplehurst Ave., Williamsport MD 21795 David Eyler--Son item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/5/2011 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Hagerstown, MD 21. Signature of Funeral Service Licensee

Scott Minnich per DVR 22. Name and Address of Facility Minnich Funeral Home 415 E Wilson Blvd., Hagerstown MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death
Months Physician/ disease or condition resulting in death) Metastatic Colon Cancer Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury signed by the attending physician and defached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be 124 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been siy completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1X Natural 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Michael McCormack, 11110 Medical Campus, Hagerstown MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signature and title of certifier

2 Deduction Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

12.27.11

29c. License number

D41667

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ John Henry Elzey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner alisbury oastal Hospice at the larg WICOMICO 5. Social Security Number 8. Date of Birth 6. Sex If Under 1 Year If Under 24 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours (Month, Day, 1 XM 2 F 215-12-6841 90 Yrs Director Aug Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location Director MD 1 ¥ Yes 2 ☐ No Wicomico Salisbury 10e, Street and Number items 23a or ner must be n 0 10f. Zip Code 10g. Citizen of What Country? Funeral 952 Gateway Street 21801 USA death n "natural", or item Aedical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.

African þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 □ Divorced American other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Environmental .Services 6th Medical Care Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Paul Elzey, Sr. Annie Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fonnette E. Simpson/grandchild 1305 Flamingo Dr., Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State cemetery, crematory or other place) Department o Important: If any injury or ö 4 Donation 5 Other (Specify) Green Acres Mem Park 11/26/2011 Salisbury, MD permit. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACCIDEN CERREROVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of, sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes To the Funeral Director; After this certificate is completed filled in by the funeral director, pag 2 No 1 Yes 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Maneter of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Natural 5 Pending work 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signatur 29c. License number 29d. Date signed (Month. Day. Year) CITE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Items 23aPtI, II per dr., 8925, 03/15/2012dhb
Registrar

Reg. No. 40364 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:15 Jeannette J. Eichelberger 2011 а December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 6530 Red Gate Circle Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 047287¥938 Country) MD 216-34-9262 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Tes 2 X No MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 Funeral 6530 Red Gate Circle United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Admin. Management Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles K. Smith Margaruite L. Belt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6530 Red Gate Circle Catonsville, MD Albert Eichelberger - Husband Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mark's Episcopal 12/12/2011 Perryville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Delyhatro Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Multi infarct Dementia years Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ending physician and use as the burial-transit Antiphospholipid Syndrome years or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death 1 Yes 2 D 9 Unknown should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page 2 this certificate 2 12 No 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 2 1 No Hospital: 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital**

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

State

10

Medical

29a. Certifier

31. Date filed (Monti

29b. Signature and title of certifier

Parles

Registrar

DHMH 17 Rev 7/2009

M.P.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lams

1001 time

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Hela hts

29c. License number

29d. Date signed (Month, Day, Year)

5

2011

December

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Leslie David Foster Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Washington Meritus Medical Center Hagerstown . Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1373M 2 | F Months 541-56-1152 63 May 12, Year) 948 Washington Director Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director Maryland Washington Fairplay 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17019 Spielman Road 21733 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian .0. Black, White, etc. þ 1 Never Married 2 Married 1X Yes Baltimore, Maryland 21215-0036 white 1 Yes 2XXNo Specify: 1988 Completed 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 3 P.S.I. Glass assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Foster Juanita Aldrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra Cynthia Foster - wife 17019 Spielman Road, Fairplay, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Carcemation 3 Removal from State cemetery, crematory or other place) Stauffer Crematory 11-29-2011 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signat of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequency of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and-trar Due to (or as a conseque e of resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Dav Pregnant at time of death signed by the a d be detached f 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed has been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe certificate 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: ျပ 1 Yes 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this of Death 27. Mann 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending within 24 hours after death. To the Funeral Director: Air completed filled in by the fu 2 🗌 No Accident Investigation 1 Yes 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

10

State Registrar

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death

(Item 23a) (Type, Print)

egistrar's Signatur

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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201

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 ancecember of Medical Facility Name (if not institution, gi **Examiner** 4b. City, Town, or Location of Death iniversity of N mole Baltimore orde Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** If Under **Director** 214-30-9619 1 □ M 2 🛣 F 79 Usual Residence of Dece 11/29/1932 MD show 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 Tes 2 K No MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 422 Windward Court 21921 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Silvand Mental Hygiene.
It is marked other than "natural", or iter 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 X No be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Teacher Private School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 traumatic Oren A. Robertson Lela Ruth Vanmeter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 <u>Tina Flanagan - daughter</u> 215 Windward Court, Elkton, Department of Healtl Important: If item 2 any injury or other 1 MD 21921 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens 12/6/2011 Aberdeen, MD Fineral Service License 22. Name and Address of Facility R.T.Foard Funeral Home, and 259 East Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a con quence of) Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 mon Day Year Pregnant at time of death 1 Yes 21 ed by the a 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 Probably 4 Unknown plnous 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 2 No 1 Yes Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 읻 1 Yes Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending injury 4 hours after death uneral Director: Aft ely filled in by the ful 1 Yes 2 No Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) To the Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Sionature 71015382 ber 012011 of death (Item 23a) (Type, Print) VIM 31. Date filed (Month, Day, Year State 5 Registrar

ernard Robert		enwell, Sr. St	tate of Maryla	nd / Depa		of Health an		Hygiene F	2 Reg. No.	
Physici I≏dical Exami		1. Decedent's Name (First, Midd Bernard	He,Last) Robert	Greenw	ell, S	r.		2. Date of Dea Month Novembe	ath Day Yea er 26, 2011	3. Time of Death 1556 hrs
		4a. Facility Name (if not institution Southern Maryland Ho				4b. City, Town, or Clinton	Location of De		4c. County o	
Funeral	-	Social Security Number	•	. Age (In yrs. I	ast birthday)	If Under 1 Yea				Birthplace (State or Foreign
Director		218-34-7359	1XM 2F	74	Yı	Months Day	s Hours M	07/27	/1937	Country Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	ition				10d. Inside City Limits
yland n-f show	ţō		e George's	Br	andywi			<u>,</u>		1 Yes 2 No
he Mary or 28a	Director	10e. Street and Number 19310 Aquasco	n Road			10f. Zip Code 2061	3		10g. Citizen of Wh	
death with the Maryland or items 23s or 28s-f sho must be notified at once	Funeral	11. Marital Status	12. Was Dece	dent Ever in U		as Decedent of His Yes, specify Cubar	panic Origin? (- American Indian, Black,
ter death		1 Never Married 2 X M 3 Widowed 4 Div	arried 1 Yes /orced if Yes, Give Year	2 No		Yes 2 X No		ito rican, etc.)		white
nours af	ed by	15. Decedent's Education (Spe	ocify only highest grade	completed)	16a. Decede	nt's Usual Occupationst of working life	ion (Give kind		16b. Kind of Bus	
136 hin 72 h e. than "1	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)		mber		,	plumbi	na
5-00 iled with Hygien the Me		17. Father's Name (First, Middle							Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To Be	Alfred Ha	amilton Ship (Type, Print)	Green		ng Address (Stree		aware or Rural Route Nu	Amanda mber, City or Towr	Ha11 n, State, Zip Code)
MD d 2 sho lith and n 27 is		A. John Greenwe	ell, Son			Box 214,			20688	
Ore, ges l an t of Hea t frite		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal from	m State	crematory or o			Date	ŀ	City or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	_	4 Donation 5 Other Si 21. Signature of Funeral Service	pecify: / Licen ee	<u> </u>		Name and Address			Chelte	
	-	23a. Part I. Enter the disease, or	y Mulo				armony	Lane, Ov	wings, MI	20736
Physician /Medical		failure. List only one cause Immediate Cause (Final disease	on each line.					ic or respiratory ar	rest, strock, of flea	Between Onset and Death
Éxaminer		or condition resulting in death)	Due to (or as a c							
	miner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause	Due to (or as a c	consequence d	n:					
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ires that the signed by I be detach	Š	Part II. Other significant condit Lung Cancer	ions contributing to o	death but not r	esuiting in the	underlying cause (iven in Part I.			Probably 4 V Unknown
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ing Phy After th	n: To	27. Manner of Death	28a. Date o	f Injury Day,Year)	28b. Time of	· · _ ·	y at Work?	28d. Describe	how injury occurre	ed
Division tal or Attendi rs after death. al Director: #	icatic	2 Accident Inves	stigation 28e Place	of Injury - At he	ome, farm, stre	eet, factory, office b	'es 2 No uilding, etc.	28f. Location (Street and Numbe	r or Rural Route Number, City
Divi	Certification:	4 Homicide dete	d not be rmined (Specify)					or Town,	State)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical ((Official City)	hysician: To the best miner:On the basis of	examination a						
To Vit	Me	29b. Signature and title of certifie	and manner sta	ited		29c. Licens	e number			d (Month, Day, Year)
KM		4-m	1.16			O.C.	V I.E.		November :	27, 2011
MYI		30. Name and address of person Jack Titus MD. Dep	who completed cause outy Chief Medica			Baltimore Stre	et, Baltimo	re, MD 21223		
St Regist		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signatu	ıге /					
DHMH 17 Rev 1/2		WI ZUI	/ Jener	13. 19	ORIGINA	M.				OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth / 199 / 2011 12:50P M Robert Geaman L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot 6109 Oyster Shell Road Ti lghman If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Sex 1X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Numbe $217 extstyle{-}58 extstyle{-}5233$ **Funeral** Months Hours Min. 10-6-1944 Director Md. Usual Residence of Decedent fshow 10d. Inside City Limits 10a. State 10b. County be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho sdical Examiner must be notified at 10c, City, Town or Location Director Talbot Md. Tilghman 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6109 Ovster Shell Road 21671 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 XNo Completed by I 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: 3 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Kitchen Helper Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Geaman Matilda Bortner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald W. Geaman / Brother 5212 Sunflower Lane Linkwood, Md. 21835 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Crem. of Delmarva 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 11-23-2011 Delmar, De. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses Hurrey & Ostrowski Funeral Home P.A. Ostrovski p.o. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph_sician/ **Emphysema** disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner C.O.P.D. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hypertension years Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month ed by the a detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney Disease Yes 2 No 3 Probably 4 Unknown has been si e 2 should b Tobacco Abuse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 XNo page certificate | Alcohol Abuse 1 Yes 2 No 25. Was case referred to medical å 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signat

933 S. Talbot St. Suite#4 St. Michaels, Md. 21663

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.A. Calhoun, M.D.

NOV 22 2011

31. Date filed (Month, Day, Year)

21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2, 2011 2:18 Рм Yvonne Brenda Gary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Care Center Towson 7. Age (In yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217-54-0522 64 Hours Min. 1 🗆 M 2 🔀 F Director Yrs May 5, 1947 Maryland Usual Residence of Decedent show 10b. County aţ 10c. City, Town or Location with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Alexandria Virginia Fairfax 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 8170 Fernlake Court 22309 United States "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: African American 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+)
-2-Elementary/Secondary (0-12) Computer Software Entrepeneaur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sylvia Trusty Dewitt Suggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clinton, MD 20735 12502 Tobias Court Robin S. Smith - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Mt. Comfort Cemetery Dec, 7, 2011 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jefferson Funeral Chapel 5755 Castlewellan Drive Alexandria, VA 22315 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cancer, Non-small cell eet and Death Immediate Cause (Final Ph_sician/ monThs disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Funeral Director: After this certificate 2 No 1 🗌 Yes Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Noisel 4 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basic of examination and/or investigation in manner is stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I only or 29b. Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar HMUES

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			For State Registrar	State	of Maryla		artment of F tificate of L		and Mental Hy	giene Reg. No. 2	011 40	1370
	Physicia Medic		1. Decedent's Name (First, Midd	le, Last) ESAU HO	117501				2. Date of De Month	eath	2 Year 3. Time o	of Death
(A)	Examir		4a. Facility Name (if not institution MEMORIAL	n, give street and nur HDSPITAL	nber)		4b. City, Town, or		of Death	4c. County	y of Death	
Hard San	Funeral Director		5. Social Security Number 220-72-7989 Usual Residence of Decedent	6. Sex 1 □ M 2 🗷 F	7. Age (In yrs. 47	-	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Bir (Month, De 0 1 – 1 0	th	9. Birthplace (State Country) Maryland	_
	should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Director	10a. State 10b. County	roline	10c. C	ity, Town or Loo Dento				10g Citizen of	10d. Inside C 1 Ye What Country?	Dity Limits
	n with the	Funeral	402 High St	treet, A	pt.2		216	529		USA	What Gounty:	
980	rs after deatl rral", or iten Examiner n	ed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🗹 Divorce	Armed Fo	2 🗷 No ve		Vas Decedent of Hi f Yes, specify Cuba		gin? (Specify Yes or No- n, Puerto Rican, etc.)		ce - American Indian, ack, White, etc.	
21215-0036	rithin 72 hour iene. r than "natu the Medical	Completed	15. Decedi (Specify only high Elementary/Secondary (0-12)	ent's Education est grade completed College (1		(Give I	lent's Usual Occup kind of work done o O NOT use retired) rk	ation luring most	t of working	16b. Kind of E	Stop	
nd 2	filed w tal Hygi d othe event,	o Be	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (First, Middle,	Maiden Surnam	ne)	
Maryland	2 should be th and Men 7 is marke traumatic	υ	Floyd 19a. Informant's Name/Relations	ship (Time Prints	Willia	ms,Sr			nora		liams	_
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Baltimore,			20a. Method of Disposition 1 Burial 2 ☐ Cremation 4 ☐ Decation 5 ☐ Other (State	Place of Dispo	sition (Name of natory or other plac	e)	Date 12-03-11	20c. Location	- City or Town, State	
Balt	permit. Page Department Important: If any injury or once.		21. Signature o, Funeral Service	Licensee fool	No contract to the contract to		. Name and Addres	s of Facilit	yBennie Sr St.,Eastor	nith Fu	neral Ho	
Mary Mary	Physician and historial-transit per executed whe bruial-transit per prize to the pr	dical Examiner	23a. Part 1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sometically list and the major of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to c. Due to	ach line. 20 47 (or as a consector	quence of): (IPID quence of): (LES quence of):	WTHEROS 677/12 MEL 170	CLEFE	cardiac or respiratory ar		Approxima Interval Be Onset and	twoon
. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. The 14 hours after death. The 15 hours after death. The 15 hours after death. The certificate has been signed by the attending physici mpletely filled in by the funeral director, page 2 should be detached for use as the but the 15 hours are the 15 hours.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	1 🔲 Live	nant at time of	al death 3	Ectopic pregnanc Other (specify)	у			ate of delivery onth Day	Year
Division of Vital Records, P.O.	equires that the sen signed by tould be detact	by	Part II. Other significant conditi	_		_		_	1		tribute to the cause of c	
Il Recol	in: The law re ificate has be or, page 2 sh	Be Completed	25. Was case referred to medical	712			26 Pla	ace of Deat		psy ormed?	Were autopsy findings prior to completion of death? 1 Yes 2 No	
Vita	hysicie his cer al direc	ပ္	examiner? 1 Yes 2 No		Inpatient 2,	ER/Outpatien	Otho	r.	rsing Home 5 Resid	dence 6 🗆 Oth	ner (Specify)	
ision of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2.	Certificate:	27. Manner of Death 1 Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could 4 Homicide determ	igation not be 28e. Place	th, Day, Year) of Injury - At h	28b. Time of injury	28c, Injury work' M 1 🗆		No	now injury occurr	red per or Rural Route Numl	ber,
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				LACEY, M	*****		FFIN L	N	DENTEN	MD	21629	
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11-08791 Rick Hecklinger Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certific	cate of	Death			Ri	eg. No.		
Physici		1. Decedent's Name (First, Midd	le,Last)				-	2	. Date of Dea			3. Time of Death
Medical Exami	iner	Ricky Jam	es He	cklinger					Month November	Day r 22, 20	Year 011	1050 hrs
		4a. Facility Name (if not institution			4	b. City, Town, or	Location of	Death		4c. 0	County of [Death
		921 Bowie Shop Road	t			Huntingtow	า			Ca	alvert	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Yea	f If Under 2	24Hrs.	8. Date of Bir	th(MM/DI	D/YYYY)	9. Birthplace (State or
Director		007 /0 50/0	4 TV 14 0 -	60	.,	Months Days	Hours	Min.			ĮF	Foreign
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with be no	Funeral	11. Marital Status		cedent Ever in U.S.		Decedent of His				- 14		American Indian, Black,
eath iter	nue	1 Never Married 2 X M	arried Armed F	orces?	If Ye	es, specify Cuban	, Mexican, P	uerto Ri	ican, etc.)		White, e	etc.
her d		3 Widowed 4 Div	orced If Yes, Give Yea		1 1	Yes 2 X No	specify:			s	pecify:	white
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S 1 a of Her t		1 Burial 2 Y Cremation	3 Removal fr	om State crema	tory or other	er place)	1301141				Callon - Ci	ly or Town, State
Page Frent		4 Donation 5 Other Sa		Metro	polit	an Crema	atory	11/2	28/2013	1 A1	lexan	dria, VA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injuryper other traumatic event, the Medical Esseminer must be notified at once	1	2 . ture of Funeral Service			22. Na	ame and Address	of Facility	Raus	sch Fur	eral	Hom	e. P.A.
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Physician		23a. Parti. Enler the disease, or		aused the death. Do n								Approximate Interval
/Medical		failure. List only one cause										Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hanging	consequence of):								
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Vis or A fire Oirec	ij			e of Injury - At home, fa	arm, street,	, factory, office bu	uilding, etc.	28			Number o	or Rural Route Number, City
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Division To the Hospital or Attenti within 24 hours after death. To the Funeral Director: /		29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my knowledge, de	ath occurre	ed at the time, da	te and place	, and du	e to the cause	e(s) and r	manner as	stated.
o the ithin a the mple	Medical		niner:On the basis of and manner st	of examination and/or i	investigatio	on, in my opinion,	death occur	red at th	ne time, date a	and place	, and due	to the cause(s)
E 2 4 8	₩.	29b. Signature and title of certifie		orog.		29c. License	number			29d. Da	ite signed	(Month, Day, Year)
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KW2.		20 Name and address (who are the	a as dans! "								
12/12		 Name and address of person Donna M. Vincenti, MI 		e of death (Item 23a) Iedical Examiner	ann v	V Raltimore	Street P.	altimo	re MD 24	223		
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St Regist	ate	31. Date filed Worth, Pay Year	11 Jensus	gistrar's Signature	arke	AS.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12/3/2011 Merle Luther Houpt 8:52 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14318 Pennsylvania Ave. Hagerstown Washington Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Min. Hours 1 M 2 🗆 F Director 84 216-22-9850 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits the Maryland Director r than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b any injury or other traumatic event, the Medical Examiner must b once. 14318 Pennsylvania Ave 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

Yes 2 \(\sum \) No Black, White, etc. by Yes Yes, Give 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Line Supervisor Electric Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harvey Edgar Houpt Esta May McCauley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve C. Houpt / Spouse 14318 Pennsylvania Ave., Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Rest Haven Cemetery 12/5/2011 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARCINOMA PANCREAS disease or condition oNTh Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or impury that initiated events Due to (or as a consequence of) Exami signed by the attending physician and I be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ DIASITES hyper TENSIO ~~ ムムレーている of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should NYPOTHEROIDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed I or Attending Physician: The after death.
Director: After this certificate I 1 Yes 2 No by the funeral director, 25. Was case referred to medical Be 26. Flace of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Division ☐ Acciden ☐ Suicide Accident Investigation M 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined completed filled in Hospital 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 29b. Signature and title of certifier ---0018019 30. Name and address of person who completed cause of death (Item 23a) (Type, Prjint) 340 HAGERSTOWN VASARI

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Nov. Day 2011 Physician/ 28, 1907 Julia Houlihan М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1719 Old Mill Lane Salisbury Wicomico 7. Age (In yrs. last birthday) 85 vre 8. Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Hours (Month, Day, Year) 020-20-5057 Director Massachusetts Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director MD Wicomico Salisbury 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1719 Old Mill Lane 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes Give Specify: Completed 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Child Care permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If them 27 is marked other amy injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Flanagan Helen Durkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ascher - Daughter Covered Bridge Lane, Fruitland, Maryland 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entomb. Wicomico Memorial Pk. 12-2-2011 Salisbury, Maryland 22. Name and Address of Facility Bounds Funeral Home E. Main Street, Salisbury, Maryland 21804 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 1 Yes 2 1 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy has Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 Tes 2 🗹 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 4127 8

State Registrar 31. Date filed (Mo

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Registrar's Sign

my

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - State Registrar				Ce	ertificate	of Dea	ath		Reg. I	No 2 U		4031
			1. Decedent's Name (First, Midd	fle, Last)							2. Date of De	ath			3. Time of Death
	Physici /Medio		Mary E	rnest	tine H	olbr	ook				Month Novemb		Day 22. 2	Year	6:05A
}	Examir		4a. Facility Name (If not institution				0011	4b. City, To	own, or Locat	tion of Death			4c. County		
			Anchorage Nursing	& Rehal	bilitatio	n Cent	er	Sal	isbury				Wico	mico	
	Funeral		5. Social Security Number	6. Sex	7. A		last birthday) If Under 1		nder 24 Hrs. urs Min.	8. Date of Bi	rth		9. Birth	nplace (State or Foreig
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	g ,		Usual Residence of Decedent			10-00									
	aryla shov	_	10a. State 10b. Count	у		10c. Cit	ty, Town or I	ocation							10d. Inside City Limit
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	ith th	Oire	10e. Street and Number					10f. Zip C	ode			10g.	Citizen of	What Cou	intry?
	be liled within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or items 23e or 28e-1 ehow event, the Medical Examinar must be mailied at	Funeral Director	7655 Hanton Ave	enue				21	.801			U	SA		
	em sum	aur.	11. Marital Status	12.	Was Decedent Armed Forces		.S. 13	Was Decede	nt of Hispanio	c Origin? (Spe xican, Puerto	ecify Yes or No Rican, etc.)	D-		ce - Amer	rican Indian,
9	or th		1 Never Married 2 Ma		1 ☐ Yes 2 ☒ If Yes, Give	No		1 ☐ Yes 2						y: B1	
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	s 1 end if Health item 27 other t	1	Charles T. Holl	orook/	Son	7001					bury,				
Ö		1	20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation	3 □Rem	oval from State		lace of Disp cemetery, cri	osition (Name ematory or oth	of er place)		Date	20c.	Location -	- City or T	Fown, State
E	Pag ment snt:	١.,	4 ☐ Donation 5 ☐ Other (_			ringhil	l Memory	Gardens	Nov.	28, 1	l He	ebron	, MD	1
saitimore,	permit. Page Department of Importent: If eny injury of once.		21. Signature of Funeral Service	Licensee	20	11	4	2. Name and	Address of F	acility Sa	alisbur	v, :	Maryl	land	
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ב כ	exe en ar rial-t	EX	resulting in death) Last		Due to (or as	a conseq	uence of):								
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	n cer andin use	lan/N	IF FEMALE: 23b. Was decedent pregnant	23c.	If yes, outcome								23d. Da	ite of deliv	very
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	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death within 25 hours after death. To the Eunerel Director: Alter this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Mec	29b. Signature and title of certific		and manner st	ated.			icense numb						, Day, Year)
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7	T	-	/ XXXX	7	leted cause of 6)/	1) 1		₹ ;	12	7'	
-	3K		30. Name and address of person	who comp	leted cause of a	death (Item	23a) (Type	Print)	2	alie	ben	1	1/12	1601	4
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31. Date filed (Month, Day, Year) **30 2011**

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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 40375 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Lee Humes 6700 Medical 4a. Facility Name (if not institution, give street and numb **Examiner** 4b. City. Town, or Location of Death 4c. County of Death KRAIONAL 5461564 HICOMICO TENINSULA Medical If Under If Under 24 Hrs Age (In vrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Director 198-34-5640 1 🛛 M 2 🗆 F 68 03/26/1943 Pennsylvania Usual Residence of Deceden ms 23a or 28a-f show must be notified at with the Maryland 10b. Count 10c, City, Town or Location Director 10d. Inside City Limits DE 1 X Yes 2 No Sussex Lewes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118 School Lane 19958 USA 1 and 2 should be filed within 72 hours after death v f Health and Mental Hygiene. item 27 is marked other than "natural", or items or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner≀ 14. Race - American Indian, Armed Forces' Black, White, etc þ 1 Never Married 2 X Married X Yes Yes. Give Baltimore, Maryland 21215-0036 2 1967 1 ☐ Yes 2 👿 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 969 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Human Resources Computer Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Leroy Humes Helen Lawrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Humes / Wife 118 School Lane, Lewes, DE 19958 20a. Method of Disposition Department of harmonic line limportant: If ite any injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peter's-PilottownRd 12/01/2011 Lewes, DE Name and Address of Facility Parsell Funeral Homes & Crematorium Kings Highway, Lewes, 23a. Part 1. Enter the disease, or co shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy perform 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ဂ္ဂ 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

E Funeral Director: A sletely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occur only one rred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 46536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kurt Wehberg, M.D., 100 E. Carroll St., Salisbury, MD 21801 31. Date filed (Month Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Asburv Jacks, Sr. 19, 2011 9:10 AM Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 30, 1940 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** 1 → M 2 □ F Months Days Hours 216-38-6171 71 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28e-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination must be motified at Director MD 1 ☐ Yes 2 No Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5305 Macs Hollow Road 20678 **IISA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married altimore, Maryland 21215-0036 Specify: Black ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 TNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mod Mechanic Power Plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolph Jones. Sr. The1ma Jacks ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5305 Macs Hollow Rd. Prince Fred., MD20678 Betty L. Jacks/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
So. Mem. Gardens Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/26/11 Dunkirk, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, Alady 1451 Dares Beach Rd. Prince Fred., MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) cho /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physiclan Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No of or Attending Physician: after death.

Director: After this certifications funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident 2 🗆 No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. M-1SICCO EWE 29b. Signature and title of certifier 29 License number

drw b

State Registrar 30. Name and address of person who complete

NOV 22 2011

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

100

d cause of death (Item 23a) (Type, Print)

alvert

32: Registrar Signature

		For State Registrar	Plea			nd / Dep	Indelible Inboderiment of Fortificate of D	lealth and I	Mental Hy	giene	gible.	40377
Physiciar Medic		1. Decedent's Name James Er		,					2. Date of Dea Month November	ath Day	Year 2011	3. Time of Death 1:00 a.m.
Examine		4a. Facility Name (if 25180 Pa		_	nber)			Location of Death	1		y of Death Mary	
Funeral Director		5. Social Security No. 577–12–57	780	6. Sex 1 X M 2 □ F	7. Age (In <i>yrs. I</i>) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Sept • 2			nplace (State or Foreign hington D.C.
aryland ka-f show ified at	- 1	Usual Residence of 10a. State Maryland	Decedent 10b. County St.Mar	cy's		ty, Town or t						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the M s 23a or 28 ust be not	Funeral Director	10e. Street and Nun		У			10f. Zip Code 20636	 б		10g. Citizen of		intry?
min or	اچ	11. Marital Status 1 ☐ Never Mam 3 🏿 Widowed		Armed Fo	2 No 1046	43-	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 XX No	n, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Bla	ce - Ameri ack, White, by: Wh	
hin 72 hour ne. than "natu te Medical	Completed	(Spe	cify only highes	t's Education st grade completed) College (1		(Giv life.	edent's Usual Occupa e kind of work done a DO NOT use retired)	during most of won	king	16b. Kind of		overnment
be filed wit lental Hygie rked other ic event, the	as l	17. Father's Name (I				Gree	enhouse Fo	18. Mother's Nan	ne (First, Middle, cet Virg	Maiden Surnar	ne)	JVELIMEIIC
d 2 should salth and M n 27 is mar er traumat		19a. Informant's Na James R.					iling Address (Street a		ral Route Number			Code)
Page 1 an ment of He tant: If iten lury or oth			☐ Cremation	3 Removal from	State	cemetery, cr Parkla	position (Name of ematory or other plac wn Mem。 Pa	ark 12-0	Date D1-2011		lle,	Maryland
permit. Depart Import any inj		21. Signature of Fur	neral Solvice (censee			22. Name and Addres	^{ss of Facility} Osk ococheagu	oorne Fu le St.	neral F Willian	lome, Isport	P.A. t,MD 21795
Physician/ Medical Examiner		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List o Final	nly one cause on ea	ich line.	eroti.	c Cardiova			rest,		Approximate Interval Between Onset and Death 15 years
be executed sician and burial-transit	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nmediate rlying iinjury	с	(or as a conseq							
e His	ē	resulting in deathy i	Last	d	01 40 4 0011004							
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 Live	come of pregna Birth 2 Feta nant at time of nown	al death 3	☐ Ectopic pregnanc ☐ Other (specify)	y			ate of deli	very Day Year
uires that the signed by ald be detact	ed by Ph	Part II. Other signif	icant conditio	ns contributing to d	eath but not res	sulting in the	underlying cause giv	en in Part I.				the cause of death?
Physician: The law req r this certificate has bee aral director, page 2 shou	Somplet								24a. Was autop perfo 1 \subsection Yes	rmed?	prior to c death?	opsy findings available ompletion of cause of
sician: s certific lirector,	To Be (25. Was case referre examiner?		Hospital:	Innetient 2	SB/Outpot	26. Pla	ace of Death (Chec	ck only one) Iome 5 X XResid	damas & C O	har (Casai	6.1
nding Phy ath. r: After this ie funeral d	Certificate: T	27. Manner of Death 1 Natural 2 Accident		28a. Date (Mon		28b. Time injury	of 28c. Injury	/ at	28d. Describe h			<u>y</u>
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funeral		3 ∐ Suicide 4 ☐ Homicide	6 Could r	nod 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, s	street, factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,
he Hospi in 24 hou he Funer ipleted fill	Medical	(Check 2	Medical E	xaminer: On the bas	sis of examinatio	n and/or inv	h occured at the time, estigation, in my opinic e, death occurred at the	on, death occurred	at the time, date a	nd place, and c	ue to the c	ause(s) and manner stated.
To to to com		29b. Signature and	fittle of certifier	eill 8	Zu-		29c. License	31563		29d. Date sign		, Day, Year) 5, 2011
77		30. Name and addre			,	, , , , ,			M:11~ 1	(D 200	5.2	
State Registra	_	31. Date filed (Mont)	h, Day, Year) EC 05	32 日	egistrar's Signa	iture	Sales.	, Great	PILLS, N	1D 206		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 27 per med cert G922 12/21/11 dk
State of Maryland / Department of Health and Mental Hygiene 40378 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:11 PM Margie Axie Johnson November 21, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Worcester Newark 8201 Newark Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🕱 F Director 99 August 28, 1912 Maryland 213-16-8299 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the IVerfeal Evanther must be notified at Director 1 ☐ Yes 2 No MD Newark Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21841 8201 Newark Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 → No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. Specify: Black Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Showell Poultry Plant Elementary/Secondary (0-12) College (1-4or 5+) 8th Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill of Health and Mental Hitem 27 is marked oth Be ပ George Purnell Isabel S. Selby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traun 8161 Newark Road - Newark, Maryland 21841 Gladys J. Fisher/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 26,11 Newark, MD Williams AME Church Cem. 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Externe disease or conditior resulting in death) /Medical Due to (or as sonsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1888 - 1974) that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) the 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? aw 24a. Was an has autopsy performed?

1 Yes 2 No The 1 ☐Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3
Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide within 24 hours a

To the Funeral E Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D.0. H44858 STE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 314 Franklin Are Suc 403 Berlin ho 21871 ide 31. Date filed (Month legistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Dona1d Н. Jeffery ΡМ 11 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at the Lake Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Min. Hours Month, Day, Yea -8-1926 (Month. **Director** Yrs. 202-20-1278 85 Pennsvlvania Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director traumatic event, the Medical Examiner must be notified 1 X Yes 2 No Worcester Ocean City ö 10e. Street and Numbe 10g. Citizen of What Country? items 23a Funeral 116 Ocean Drive 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. P. þ 1 X Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Maryland 21215-003 and Mental Hygiene.
is marked other than "natural" 3 Divorced 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Maint. Specialist U. S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be ment of Health and Menta Jeffery Jennie Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce, Donna Braksator- Niece 54 W. Kyla Marie Drive, Newark, Delaware 19702 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Magdalene Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12-2-2011 Ringtown, Pennsylvania Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARCIDOUA MALIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or): or Attending Physician; The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the a should be detached f Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an page 2 s autopsy prior to completion of cause of death? performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 21 No Other: Certificate: To 4 ☐ Nursing Home 5 ☐ Residence 408PICK 1 Inpatient 2 I ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and le of certifier 29d. Date signed (Month. Dav. Year) 11-28-2011 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 2 180 2 SALISBULLERY Bre State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year **Physician** 2:45 PM George M. Justice, Sr. Vovember 26 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Living otMarikin Princess Anne Domerset Denior urora If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral 1 ☑ M 2 ☐ F Director 217-30-8746 June Maryland Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits the Marylar 28a-f shov traumatic event, the Medical Examiner , ust be notified at 1 □Yes 2 No Director Maryland Wicomico Quantico 10e. Street and Number 10g. Citizen of What Country? 23a or death with 26058 Nanticoke Road Funeral 21856 U.S. or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ✓ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban-Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:1956-59 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Produce Manager is marked other Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Eldridge O. Justice Jeanette L. Vickers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health a Important: If item 27 is any injury or other trauonce. George M. Justice, Jr. 26058 Nanticoke Road, Quantico, Md. 21856 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 12-2-2011 Salisbury, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home MO0295 11673 Somerset Avenue, Princess Anne, Md. 21853 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm viate Cause (Final dise se or condition resulting in death) **Physician** 5 years)ementu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events anything is death) Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ⋛ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 2 \square No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATESAW

29b. Signature and title of certifier

DR. USITA

anh Ninh



Registrar

29c. License number

D051359

StrisBURY 1 MD 21804

29d. Date signed (Month, Day, Year)

November 28/5 2011

11-08672

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

atricia Kenton	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No.	4038
Physiciar Medical Examin	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	of Death
weulcai Examini	Patricia Ann Kenton November 18, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
and way.	Glebe Road and Easton Bypass Easton Talbot	
Funeral Director	5. Social Security Number 213-42-0041 7. Age (In yrs. last birthday) Anoths 7. Age (In yrs. last birthday) Yrs. 1 Months 1 Days 1 L2-04-1940 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Foreign Country)	(State or MD
any		side City Limits
Maryland 28a-f show d at once.	MD Talbot Easton	Yes 2 X No
eath with the Maryland items 23a or 28a-f sho	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10182 Hailem School Rd 21601 USA	
ិ ៦៩ [11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 14. Was Decedent Ever in U.S. 1 Yes 2 No 1 Yes 2 No specify:	an, Black,
17215-0036 Id be filed within 72 hours after fental Hygene. aarked other than "natural", event, the Medical Examiner.	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
36 hin 72 e. than "	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 16b. Kind of Business/	
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21215-0036 hould be filed within 7. hould Mental Hygiene. is marked other than rite event, the Medica.		do)
MD 21 nd 2 should alth and Me m 27 is ma aumatic er	Robert H. Kenton Sr (husband) 10182 Hailem School Rd Easton MD 21601	ie)
re, rand free free free free free free free fre	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State MD Eastern Shore VA	tate
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other in injury or other trannatic event, the Medic of the Medical Page 1 and	4 Donation 5 Other Specify: Cemetery 11-28-2011 Hurlock MD	
Ball permit Depart Impor	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Hom 200 S. Harrison St Easton MD 21601	e, P.A.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appro	en Onset and
/Medical Examiner	Immediate Cause (Final disease a Multiple Injuries	Death
	or condition resulting in death) Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
-1 5	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
xecuted		-
60, tte be execut hysician and e burial - tra	IF FEMALE: 23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Functal Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit or extending the physician and the period page 10 or the physician and the physician a	Do not be a second to pregnant in the past 12 months? Continue of death 1	Year
O. B. at the de d by the stached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	e of death?
s, P.O uires that t n signed by d be detac		
Records, The law requires ficate has been sig	24a. Was an 24b. Were autopsy fine autopsy performed? 24b. Were autopsy fine prior to completion death?	
tal Rec		2 No
of Vital ng Physician ther this certi		
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Division al or Attendii as after death. al Director: /	Natural 5 Pending Investigation 18 Pending Investigation 19 Pending Inv	
Division of spiral or Attending hours after death. Interal Director: Aft y filled in by the func	3 Suicide 6 Could not be determined (Specify) Local Street (Specify)	
Div To the Hospital or within 24 hours afte To the Funeral Dis completely filled in		s)
E 3 E 8		Year)
	O.C.M.E. November 19, 2011	
3	30. Name and address of person who completed cause of death (Item 24.) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Stat Registra		
DHMH 17 Rev 1/200		
OCME 2006		

1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

2. Date of Death

40382

3. Time of Death

Physiciar /Medica Examine
Funeral
Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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arried 2 Mar 4 Divorced 15. Deceder	Armed F				21793				States		
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ecify only highe	nt's Education est grade completed	1	16a. Deced	dent's Usual O kind of work d DO NOT use re	ccupation one during mo	ost of working	16	16b. Kind of Business/Industry			
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n 5 Other (S	· · · · · · · · · · · · · · · · · · ·	Calv		emeter 2. Name and A		2, 201		Pennsylva			
Funeral Service	Leito					2		ineral Hor erick, Ma	mes, r.A. ryland 2170		
er the di leas , o eart failure. List e (Final tion	t only one cause on	caused the death. each line.		ter the mode of	dying, such a	is cardiac or r	espiratory arrest	ί,	Approximate Interval Between Onset and Death How THS		
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							1 ☐ Yes	2 □ No 3 □ F	Probably 4∏Unknowi		
							24a. Was an autopsy performe	prior to death?	autopsy findings available o completion of cause of es 2 \square No		
erred to medica	ıl .				26. Plac	ce of Death (Check only one)				
XΝο	Hospital: 1	Inpatient 2 EF	R/Outpatien	nt 3□ DOA	Other: 400 N	dursing Home	∍ 5 ☐ Residen	ce 6 □Other (Sp	ecify)		
-	ng (Mo		8b. Time of Injury	of 28c.			d. Describe how	injury occurred			
eath 5 □ Pendir investi		be of injury - At hom	e, farm, str	reet, factory, of	fice	28	f. Location (Stree City or Town,	et and Number or F State)	Rural Route Number,		
eath 5 Pendir investi 6 Could	nined buil	dirig, etc. (Specify)									
5 Pendir investi 6 Could detern	ng Physician: To the Examiner: On the	ne best of my knowledges of examination	edge, death on and/or in	h occurred at t	he time, date a	and place, an eath occurred	nd due to the cau	ise(s) and manner are and place, and du	as stated. ue to the cause(s)		
	eath 5 Pendir investi 6 Could	bath 28a. Dat 5 Pending investigation 6 Could not be 28e. Plat	Hospital: 1 Inpatient 2 El seath 5 Pending investigation 6 Could not be added not	Hospital: 1 Inpatient 2 ER/Outpatier bath 5 Pending investigation 6 Could not be 28e. Place of injury - At home, farm, str	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ath 5 Pending investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, of	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 44 A Seath Supervised investigation 6 Could not be about the following investigation at the following investigation of the following in	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home seath 5 Pending investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28e.	ferred to medical Could not be described as the process of the	1 Yes 2 No 1 Yes Vertical Yes Yes		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 29, 2011 Seray Kabba Ahmed 12:38 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Prince Georges Hospital Center Cheverly Social Security Number If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Countal Mest Africa Months Hours 213-87-2924 Director 1 **X** M 2 □ F 43 May 12, 1968 Sierra Leona 10d, Inside City Limits 28a-f shov 10c. City. Town or Location at 10a. State Director Examiner must be notified 1 X Yes 2 No Maryland Prince Georges Landover Hills 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? West 0 Funeral items 23a 3809 - 64th Avenue; Apt. 4 20784 Sierra Leone, Africa 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. o Yes 2 X No Yes, Give 1 Never Married 2 Married 2 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. **Black** Specify: "natural", 3 Widowed 4 N Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed None 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H is marked of Alhaji Ahmed Kabba Amie Mbayo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 3809 - 64th Avenue; Apt. 4; Hyattsville, Maryland 20784 Edwina Saidu (Sister) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State oartment of Hoortant: If ite Dec.17,2011 1 X Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or Donation 5 Other (Specify) Gateof Heaven Cemetery Silver Spring, Maryland Signaur of Funer Name and Address of Facility R. N. Horton Company Morticians, Inc.: 600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final ATAL Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 2 certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Inpatient 2 🗱 R/Outpatient 3 🗌 DOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and/or investigation in according to the cause of examination and or examina Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 2011 cemson Inpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person GRIFFIN DAVIS HOSPITAL DR CHEVERLY MD 20785 3001 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

December in terms from Actions, Actions and Service of Control				1 - For State Registrar	State of	Marylan		artment of I		and M		ene g. No. 2	011	403	384
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State Person No. Call vert	9			4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City, Town,	or Location o	of Death		4c. Co	ounty of Death		
Social Security Numbers Social Security				3787 Harbor Roa	ad			Chesape	eake B	each			Calvert		
Decorption of the property of		Funeral			. Sex 7.	Age (In yrs.	last birthday)	if Under 1 Year	If Under	24 Hrs.	(Month, Dav.	Year)	9. Birthp	lace (State or	r Foreign
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25. Was case referred to medical examiner? 1	<u> </u>	Th ate pag	ខ្ល										1 Yes	2□ No	
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State		α,			1000	MO		38 W/G	SALIW	ac	7, 1	VI	a m	CH. YM	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death LEE DOUGLAS 4:45 PM GEORGE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MARDELA SPRINGS 8954 ATHOL ROAD WICOMICO If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 1 **X** M 2 □ F Days 64 222-30-8432 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits WICOMICO MARDELA 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8954 ATHOL USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 67-70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) COUNSELOR CRISIS COUNSELING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEE B. LEROY GEORGIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERESA LEE 8954 ATHOL RD MARDELA SPRINGS MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State EASTERN SHERE VETERANS CEM 11-30-11 HURLOCK, MD 4 Donation 5 Other (Specify)

permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

Examine

Physician/Medical

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Completed

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Certificate:

Medical

29b. Signature

Physician/

Medical

Examiner

Funeral

Director

28a-f show

must be notified at

"natural", or items 23a

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Baltimore, Maryland 21215-0036

Director

Funeral

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Ph_sician/ Medical Examiner

21. Signature of Funeral Service Liesnas 22. Name and Address of Facility PLEISCHAUER FUNGRAL HOME, POBJOL, GREENWOOD, DE 19950 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. MALIGNANT RSORAD RAL Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2/ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DO058410

and attending physician for use as the burial Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir

Registrar DHMH 17 Rev 7/2009 address of person who completed cause of death (Item 23a) (Type, Print)

PU

		• • • • • • • • • • • • • • • • • • • •	of Maryland / Dep			•
		1 _ State		rtificate of Dea	th	Reg. No. 2011 40381
_		Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of De	ath 3. Time of Death
Physicia /Medic		WILLARD E. LAND	ON, JR.		Novembe	er 30, 2011 1:11 P M
Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or Locat		4c. County of Death
est.		208 S. Somerset Avenue		Crisfi		Somerset
Funeral Director		5. Social Security Number 6. Sex 1 1 1 M 2 1	7. Age (In yrs. last birthday, 81 Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. 8. Date of Bir urs Min. (Month, Da 07/31/1	th ay, Year) 9. Birthplace (State or Foreign Country) Maryland
	}	Usual Residence of Decedent	01		0//31/1	1930 Marytana
rylan	b	10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits
ne Ma 18a-f	ecto	Maryland Somerset	Cris	field		1X Yes 2 □ No
with t	Funeral Director	10e. Street and Number 208 S. Somerset Avenue		10f. Zip Code 218	17	10g. Citizen of What Country? U.S.A.
Jeath	rera	11 Marital Status 12. Was D			c Origin? (Specify Yes or No xican, Puerto Rican, etc.)	
or ite		Armed	s 2 No 1955-	If Yes, specify Cuban, Me> 1 ☐ Yes 2 ☑ No Spe		
INCLESSION OF THE MANY AND THE MENT AND THE	d by	3 ☐ Widowed 4 ☐ Divorced Year of	or Dates: 1959		Solly.	Specify: White
n 72 h	Completed	15. Decedent's Education (Specify only highest grade complete	ed) (Give	edent's Usual Occupation e kind of work done during i DO NOT use retired)	most of working	16b, Kind of Business/Industry
vithii jiene.	d mo	Elementary/Secondary (0-12) Colleg	e (1-4or 5+) Mech			Paint Brush Mfg.
	Bec	17. Father's Name (First, Middle, Last)		18. M	Mother's Name (First, Middle	, Maiden Surname)
Idel yidello Z IZ 2 should be filed within 1 and Mental Hygiene. is marked other than raumatic event, the	2	Willard E. Landon		Al	va Wilson	
Darith Dole, Intal yial praint Pages 1 and 2 should be Department of Heath and Menti Important; If item 27 is marked any Injury or other traumatic evence.		19a. Informant's Name/Relationship (Type. Print)		-		er, City or Town, State, Zip Code)
1 and 1 and Healt em 2		Patsy Landon (Wife) 20a. Method of Disposition			AveCrisfiel	20c. Location - City or Town, State
t. Pages tment of tant; If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other place)	a 12/01/2011	Delmar, DE
artme ortan Injur		21. Signature of Funeral Service Licensee			acility Funeral Ho	
Deparii Depari Impor any In		Robert H. Bradshaw,			ons funeral Ho StCrisfield,	
		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of				rrest, Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		ASCVD		Onset and Death
/Medical Examiner		resulting in death) Due	to (or as a consequence of):			
	P.	Sequentially list conditions,	to (or as a consequence of):			
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to for as a consequence of.			
be executed ician and burial-transit	ш	resulting in death) Last C. Due	to (or as a consequence of):			
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attendation of the contract of	ian/	in the past 12 months?		☐ Ectopic pregnancy ☐ Other <i>(specify)</i>		23d. Date of delivery Month Day Year
by the	ysic		nknown			
ires that signed by the deta	by Pt	Part II. Other significant conditions contributing to	o death but not resulting in the u	ınderlying cause given in P	Part I. 23e. Did t	tobacco use contribute to the cause of death?
w require s been sig should b					1 🗆	Yes 2 No 3 Probably 4 Unknown
e law n	Completed				24a. Was	an 24b. Were autopsy findings available prior to completion of cause of
ician: The l	S .				perfo 1 □ Yes	ormed? death? 2 ☑No 1 ☐Yes 2 ☐No
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:		Other	Place of Death (Check only o	one)
Phys rr this	2	102 tes 2 1100 1 1	☐ Inpatient 2 ☐ ER/Outpatie ate of Injury 28b. Time of	III 3 LI DOA 4L		dence 6 Other (Specify) how injury occurred
nding Phy th. :: After thi e funeral	Certification:	1 ☑ Natural 5 ☐ Pending (A 2 ☐ Accident investigation	flonth, Day, Year) Injury	Work? M 1 □ Yes		nor injury cocurred
Atte er deg rector	ii iii	3 Suicide 6 Could not be	ace of Injury - At home, farm, st illding, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number,
ital or rrs after ral Dia led in	Cer		maning, etc. (opeony)			mi, otate)
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aff completely filled in by the fun	ical	(Check only 2 Medical Examiner: On th	e basis of examination and/or in	th occurred at the time, dat nvestigation, in my opinion,	te and place, and due to the , death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
the the orthe orthe orthe orthe	Medical	one) and m 29b. Signature and title of certifier	nanner stated.	29c. License numb	ber	29d. Date signed (Month, Day, Year)
¥ ≥ ₽ 8			1-4-01		098	December 1, 2011
10.V	-	30. Name and address of person who completed c	ause of death (Item 23a) (Type.			December 1/ 2011
Thi		Vijav Karumbunathan. M	I.D 201 Hall	Highway - C	risfield. MD	21817
Stat		31. Date filed (Month, Day, Year)	Registrar's Signature	1		
Registra	ir	DEC 0 1 2011	Clown B.	gares		

			Please Type or Prin						_	gible.
			for State of Ma	•	Department Certificate			/lental Hy	2	011 1.038
	Diversity		Decedent's Name (First, Middle, Last)		Cortinoato	0, 00	atri	2. Date of De		3. Time of Death
	Physicia Medi	cal	Thomas Henry Meushaw Jr. 4a. Facility Name (if not institution, give street and number)					Noven		305AM
	Examir	ier	Memorial Hospital Ea	5ton (In yrs. last birth	Ea	Sta	cation of Death	8. Date of Bir	4c. County	bot
1	Funeral Director		215-32-6163 Usual Residence of Decedent	76			Hours Min.	% Date of Bir (Month, Da 9-8-193	y, Year)	9. Birthplace (State or Foreign Country) MD
	yland f shov ed at	ctor	10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limits
	ne Mar or 28a	Dire	MD Talbot 10e. Street and Number	Ea	aston 10f. Zip Co	ode			10g. Citizen of	1 X Yes 2 No
	death with the Maryland items 23a or 28a-f show ner must be notified at	Funeral Director	29242 Pin Oak Way			1601			USA	What Country?
920	er dea or ite niner	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E-Armed Forces? 1 Xyes 2 If Yes, Give Year or Dates,		13. Was Decedent If Yes, specify	Cuban, N	Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - American Indian, ck, White, etc.
5-0	72 hours after n "natural", or tedical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)		L Decedent's Usual C (Give kind of work o			ina	16b. Kind of B	usiness/Industry
Maryland 21215-0036	should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", aumatic event, the Medical Exar		Elementary/Secondary (0-12) College (1-4 or 5-	-)	ife. DO NOT use re Lnance Di	tired)			Distri	ct Court of Maryland
nd	filed val Hyg	To Be	17. Father's Name (First, Middle, Last)			18	3. Mother's Name	e (First, Middle,	Maiden Surnam	•
ryla	ould be file d Mental marked o matic eve	Ĕ	Thomas Henry Meushaw 19a. Informant's Name/Relationship (Type, Print)	T			Thelma S			
	and 2 sho Health an tem 27 is	- 11	Lynda C. Meushaw (Wife)		Mailing Address (Si					State, Zip Code)
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State	cemetery	Disposition (Name of crematory or othe	r place)	· i	Date	20c. Location	- City or Town, State
Him	permit. Pag Departmen Important: any injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Sig of ry of f f ry Service Licens	Chesar	eake Cre					sville, MD
Ba	Departiment Depart	9	13. Keet Down	CFS	Fellows	, He: Harr	lfenbeir ison St	n & New	nam Fune n MD 216	eral Home, P.A.
	Physician/ Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a	ein(i	ot enter the mode of	f dying, s		r respiratory ar	rest,	Approximate Interval Between Onset and Death
		Examiner	cause. Enter Underlying	consequence or	j.	_				2
	e executed cian and vurial-transit		Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a	consequence of):					
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Box	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physic stely filled in by the funeral director, page 2 should be detached for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of the past 12 months? 4 ☐ Pregnant at the past 12 months?	Fetal death	3 Ectopic preg 5 Other (speci					ite of delivery onth Day Year
s, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death bu	t not resulting in	the underlying caus	se given i	in Part I.			ribute to the cause of death?
Records,	e law requ has been ge 2 shou	Completed						24a. Was autop	psy	Were autopsy findings available prior to completion of cause of death?
al R	ician: The la certificate ha rector, page		25. Was case referred to medical		2	26. Place	of Death (Check	1 Yes		1 Yes 2 No
of Vital	Physici this cer al direc	은			patient 3 DOA	Other:	,		dence 6 🗆 Oth	er (Specify)
n of	iding Phy th. After thi funeral	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Year) 28b. Tir inj	ury	Injury at work?	2 🗆 No	28d. Describe h	ow injury occurr	ed
Division	al or Attendir s after death. I Director: Af ed in by the fu	Certificate:	3 Suicide 6 Could not be	y - At home, farn (Specify)	n, street, factory, of			28f. Location (S City or Tow		er or Rural Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b	Medical	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 3 Certifying Nurse Practitioner: To the	amination and/or	investigation, in my	opinion, d	leath occurred at	the time, date a	nd place, and du	e to the cause(s) and manner stated
	Nithi Vithi Com		29b. Signature and title of certifier		29c. Lio	cense nui	mber 546		29d. Date signed	d (Month, Day, Year)
	S+VA		30. Name and address of person who completed cause of dea				Washin	gton St	Easto	n MD 21601
	Stat Registra	e ır	31, Date filed (Month, Day, Year) 32, Registrar NOV 3 0 2011	s Signature	Sale					

DHMH 17 Rev 06-2011

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			State of Maryland / Dep		/lental Hygie	ne
				rtificate of Death		.No. 2011 40388
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) James Cleon Macintire		2. Date of Death Month 11-26-2	Day Year 3. Time of Death 458 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	11-20-2	011 458 A M
) LAGITIEI	ICI	3745 Seymour Drive	Trappe		Talbot
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8, Date of Birth	9. Birthplace (State or Foreign
	Director		217-50-8145 1 M 2 L F 65 Yrs.	Working Bays Floars Will.	7-06-1946	ar) Country) MD
	and show at	or	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryla 18a-f	rect	MD Talbot Trappe			1 🔀 Yes 2 □ No
	a or 2 be no	al Di	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	th with ns 23 must	Funeral Director	3745 Seymour Drive	21673		USA
	ır dea or iter niner	by Fu	11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
8	rs afte rral", o Exan		3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ីX No Specify:		Specify: White
2-0	2 hour	plet	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ing 16	b. Kind of Business Industry
121	thin 7: ane. than	Completed	Elementary/Seconday (0-12) College (1-4 or 5+) life. D	O NOT use retired) Manager		utomotive
d 2	e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
<u>lan</u>	l be fil fental rked tic ev	၉	Bradford B. Macintire	Elvira S	. ,	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		1	ng Address (Street and Number or Run	al Route Number, Cit	y or Town, State, Zip Code)
≥	and 2 s Health tem 27				rappe, MD	21673
Baltimore,			20a. Method of Disposition 20b. Place of Disposeration 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State Changes, cerebration.	matory or other place)		c. Location - City or Town, State
≣	permit. Page Department of Important: If any injury or once.		_			tevensville, MD
Ba	Depart Impo		I None and I I I	Pellows, Helfenbei 200 S. Harrison St	n & Newna	m Funeral Home, P.A.
Н			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition MULTIPLE	MUELON	MA	Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):			
		er	Sequentially list conditions, if any, leadin to immediate b. Due to jor as a consequence of process.			
	ted insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury			
	be executed sician and burial-transi	EX	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
ō	ا کر ا	dical	d			
200	certifica nding ph use as tl	Physician/Me	IF FEMALE: 23b. Was decodent present. 23c. If yes, outcome of pregnancy			
ROX	death ce he attend ed for us	cian	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Œ	he de ny the ached	hysi	1 Yes 2 No 9 Unknown			
r Ö	that thread b	by P	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ďS,	quires sen sig ould b	ted			1 🗆 Yes	2 No 3 Probably 4 Unknown
Hecords,	faw re nas be e 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ž	r. The		25. W		performed	
VItal	siciar certif irecto	œ .	25. Was case referred to medical examiner? 1 Ves 2 No Hospital:	26. Place of Death (Check		
0	g Phy er this eral d	e: To	27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at	me 524 Residence 28d. Describe how in	e 6 Other (Specify) njury occurred
on o	endin sath. or: Aft he fur	ficat	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		
DIVISION	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
ź	pital ours a eral c	edical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	Occurred at the time, date and place, or	d due to the course) and manner as stated
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Medi	(Check 2 Medical Examiner: On the basis of examination and/or inves only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred a	the time, date and pl	lace, and due to the cause(s) and manner stated.
	Vithi To t		29b. Signature and title of certifie	29c. License number		Date signed (Month, Day, Year)
			Muchava Mosteury Me.	1 16604		0 EMBER 28, 2011
٠,٠	4V+E		30, Name and address of person who completed cause of death (Item 23a) (Type, F M1CHAR A. WOSKEWICZ M): 83	Chesapenke Del	UE- CAMIX	RIDGE MADULALS
	Stat	.e	31. Date filed (Month, Day, Year) 32. Registrar's Signature		, 01/100	THE POLITICAL PROPERTY OF THE
	Registra	ir	NOV 29 2011 June 1. 10	No.		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40389 for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Margaret Routzahn Miller 8:15A M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Walkersville Devotion Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country Hours 47971915 212-38-2413 Usual Residence of Decedent Director 1 🗆 M 2 😾 F 96 28a-f show 10d Inside City Limits 10a. State 10h County 10c. City, Town or Location must be notified at Director SC Myrtle Beach 1 ¥ Yes 2 ☐ No Horry 10f. Zip Code 29588 o 10e. Street and Number 10g. Citizen of What Country? 709 Sanibel Circle 23a Funeral IISA within 72 hours after death with or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Examiner Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2X No Specify. "natural", 3 Widowed 4 N Divorced Completed Year or Dates other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. public Elementary/Secondary (0-12) College (1-4 or 5+) 5+ teacher schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Routzahn Grace Wilcox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
709 Sanibel Circle, Myrtle Beach, SC29588 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important; If item 27 is any injury or other trau Charles Miller (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🗆 Bu al 2 🛣 Cremation 3 🗌 Removal from State Smithsburg Crematory12/1/2011Smithsburg, nation 5 Other Specify) Donald Address of Facility on Funeral Home Middletown, MD se, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final MITERLY DISETHE onoumy/ Propintion/ ATHENO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DEMENTIA Sequentially list conditions n any, reading to immediate cause. Enter Underlying Due to for as a consequence of Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and -tra that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a ld be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has performed? this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 X No မှ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral (27. Manner of Dea 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🕽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 12-01-2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 TollHouse - Ave tredende, Mn 21701 IBTE A Mr 31. Date filed (Month, Day, Year, 32, Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lorraine Mildred Moffatt 4:15 PM December 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Elkton Care & Rehab Center Elkton Cecil Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Hours 482-22-4823 01/13/1926 Country) **Iowa** Director 85 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits New Castle DE Bear 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2124 Meredith Way 19701 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 - Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Bookkeeper Lumber Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Franklin Cook Julia Marie Agerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia J. Booth / daughter 2124 Meredith Way, Bear, DE 19701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 X Cremation 3 - Removal from State United Crematory or other place) 12/08/2011 Newark, DE 4 Donation 5 Other (Specify) Services 21. Signature of Funeral Service Licensee Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702 ine Crane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Alhoroscleratic Heart Disease Immediate Cause (Final Physician/ vears disease or condition Medical resulting in death) **Examiner** years Sequentially list conditions, Examiner trany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month sate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheuma Ind Arthritis 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital Other: ၉ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune

completed fi To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of o 29d. Date signed (Month, Day, Year) Sichder SMD. 10023322 12.5.2011. rson who completed cause of death (Item 23a) (Type, Print) High ST, Eleten MD 21921

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 \(\Omega\) For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month November 29, 2011 11:55 AM Virginia Elizabeth Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Golden Living Center Hagerstown | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) | August 30,1920 | Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 K F Director 216-14-5774 91 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if Health and Mental Hygiene. Item 27 is marked other then "netural", or Iteme 23s or 28s-f show other traumatic event, I've Medical Examinat must be notified at 1 XYes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 750 Dual Highway USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "netural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 Nidowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Resteraunt Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Kiefer Eckis, Sr. Anna Mae Postetter ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Miller Sr, (Son) 15 Country Lane Apt. C Falling Waters, WV 25419

Disposition
2 Of Cremetion 3 C Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Samuel 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny Injury or once. 4 Donation 5 ☐ Other (Specify) Greenlawn Mem. Park | Dec. 2, 2011 Williamsport, MD 22. Name and Address of Facility Osborne Funeral Home P.A. 21/Signature 425 S. Conococheague St. Williamsport, MD 21795 23a. Fall. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician & years disease or condition resulting in death) /Medical Due to (or as@consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the burial-transit requires that the death certificate be executed Exam Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ned by the a ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þe 1 Yes 2 No 3 Probably 4 Unknown should peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has b lirector, page 2 s autopsy performed?, Yes 200 No 1 ☐ Yes To the Hospitel or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 2 ER/Outpatient 3□ DOA After this 28b. Time of Injury filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 / Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 128365 11/30/11 30. Name and address of person who d controlleted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

368

SHA

32 egistrar's Signature

null Street - Heigesterm MO 21740.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ McCARNEY, SR. December 5, 201^{Year} Jack L. 3:30ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 146 East Washington Street Hagerstown Social Security Number 8. Date of Birth
(Month, Day, Year)
Aug. 9, 1945 **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Min. 1X M 2 1 Hours 220-42-5251 Director Maryland 66 Aug. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 U.S.A. 146 East Washington Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 2 🔀 No white 1 ☐ Yes 2 X No Specify: Hygiene. other than "natural", If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) groom horse racing and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frank McCarney Helen P. Everly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin R. Russell, III-Friend 21782 17421 Taylors Landing Road, Sharpsburg, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Lawn Memorial Date 1 X Burial 2 Cremation 3 Removal from State December 8, Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a-consequence Examiner u Sequentially list conditions, rr any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence off: Exami that the death certificate be executed burial-transi Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Completed 1 Yes 2 No 3 Probably 4 hknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page certificate 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending iniun after death.

Director: Aft 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide M 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifie

JW-Z State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

M 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40393 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Milburn Month Marsh a 11:350 , ovember Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 02/03/1954 212-66-3135 **Director** 1 M 2XX 57 Tennessee Usual Residence of Decedent 28a-f show with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Prince George's Bowie 1 Yes 2XX No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a ol dical Examiner must be Funeral 1106 Patriot Lane 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Yes, Give 1 Yes XX No Specify. Black 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Financial Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Crestle Annie L. Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Panorama Drive Oxon Hill, Maryland 20745 Crestle Watson / Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/9/2011 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. al Service License 22. Name and Address of FacilityGeorge P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each inc. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Duodenal (unier disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months? Month Day Year signed by the at Id be detached for Pregnant at time of death 2**X X**No 1 Yes 2X 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 performed this certificate 2 No Yes 2 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 4 Nursing Home 5 Residence 6 other Specific ent hospice 1 Tyes 2 🗹 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Director: After the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after

To the Funeral Directory filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ms Lyppathem.D 00057465 11/30/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 5203 Baltimore MD 21209 28355mily S Rayapakse IM'D

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) **JEC 0 5 2011**

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2	0	-	40	3	9	

			1- For State Certification Cer	ficate of Death	Reg. No.	
•	Physic ical Exan		1. Decedent's Name (First, Middle, Last) Armon AL M	artin	2. Date of Death Month Day Year November 25, 2011	3. Time of Death 0903 hrs
	Ĭ.		Facility Name (if not institution, give street and number) 9410 Spring House Lane	4b. City, Town, or Location of Deat Laurel		
	Funera		5. Social Security Number 6. Sex 7. Age (In yrs. las	• • • • • • • • • • • • • • • • • • • •	s. 8. Date of Birth (MM/DD/YYYY) 9. Birth	thplace (State or
	Directo	r	167-62-4236 1⊠M 2□F 3 Usual Residence of Decedent	Yrs. Months Days Hours Mir		untry) PA
	death with the Maryland or items 23a or 28a-f show any must be notified at once.			own or Location		10d. Inside City Limits
		ţ	DE KeNT 10e. Street and Number	Dover 10f. Zip Code	10g. Citizen of What Cour	1 X Yes 2 No
	, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. rem 27 is marked other than "natural", or items 23a or 23a-fab tranmatic event, the Medical Examiner must be notified at once	Director	327 Paradee Drive	19904	USA	,
	leath wit	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		can Indian, Black,
	s after of	by F	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	1 Yes 2 No specify:		.acK
	72 hour n "natu	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use rel	ired)	On the
	5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name (First, Middle, Last)	Management Hna	Jyst StofDE, 7	ept lublichtealth
	21215-0036 unld be filed within 7 Mental Hygiene. marked other than	Be	Archie Andrew Mi	artin Vernido	Mae Jacobs	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hot Department of Health and Mental Hygene. Important: If item 27 is marked other than "nat injury or other transmatic event, the Medical Exp	ြင	19a. Informant's Name/Relationship (Type, Print)	2240 1 7	Rural Route Number, City or Town, State, Vとく、D F / 990 Y	Zip Code)
	Pages 1 and 2 shonent of Health and ant: If item 27 is or other traumati		20a. Method of Disposition 20b. Pla	ce of Disposition (Name of cemetery, matory or other place)	Date 20c. Location - City or	Town, State
	다 된 다 모 교		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address of Facility	4-2011 Dover, D	E
		_	Vannie A Maris	Deborah EHarris-Nock	Fineral Home, POB22, Bris	geville DE19933
	Physiciar _∰edica		23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line. Immediate Cause (Final disease a Cardiac Arrhyth		or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
	Éxamine		or condition resulting in death) Due to (or as a consequence of):	un ca		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
	bed isit	Examiner	(Ulsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	7 60, cate be executed physician and he burial - transi	Medical	d. ☐ AMENDED 23a,pt.II	,27,per me,g923 1-9-1	2 sm	
	3760, ificate be ig physicia s the buris		IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth		23d. Date of delivery	ay Year
ì	BOX 68 death certification attending of for use as	Physician/	past 12 months? 4 Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown			ay roan
	P.O. By sthat the de gned by the e detached f		Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did tobacco use contribute to t	he cause of death?
1	dS, P.C quires that en signed uld be deta	ted by	Sleep Apnea; Lymphocytic Thyro	oiditis	1 Yes 2 No 3 Prob	ably 4 ✔ Unknown opsy findings available
	ecor ne law re te has be ge 2 sho	Completed			autopsy prior to comperformed? death?	ompletion of cause of
!	inn: Ti sertifica ctor, pa	Be Co	25. Was case referred to medical examiner?	26.Place of Death (Check		s 2 No
	F VII Physic er this or	[유	1 ✓ Yes 2 No	Noutpatient 3 DOA Other Nursin Bb. Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 Other	Scene
	ION O tending eath. or: Afte the fune	tion:	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	28d. Describe how injury occurred	
	UNISION Of VITAL RECORDS, tal or Attending Physician: The law require star death. all Director. After this certificate has been si led in by the funeral director, page 2 should b	Certification:	3 Suicide 6 Could not be determined	e, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rur or Town, State)	al Route Number, City
•	fill ou pi		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge,			
	To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/ and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	
	,		high, us	O.C.M.E.	November 26, 20	
			30. Name and address of person who completed cause of death (Item 23 Ling Li, MD Assistant Medical Examiner 900 W.	•	223	
		tate	31. Date filed (Month, Day, Year) 37. Registrar's Signature	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23a,PtI,II,25,27,28a-f per me,2923,01/03/2012dhb

Certificate of Death

Reg. No. 40395 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bruce 5:20PM Marten Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANCHORAGE NURSING AND REHABILITATION WICOMICO SALISBURY 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min 1**X** M 2 □ F Days Hours **Director** 216-32-7663 76 /06/1935 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am purply or other traumatic event, the Medical Examiner must be notified a once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico 1 X Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Union Ave. 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Marine Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White Completed 3 XWidowed 4 Divorced Year or Dates. Corp 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Russell L. Marteny Pearl R. Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Marteny/Son 2601 E. Ocean Blvd., Unit 306, Long Beach, CA90803 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Salisbury Crematory 11/29/2011 4 Donation 5 Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee Name and Address of Facility HOLLOWAY Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ erebroVascula Medical resulting in death) Du (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran FICATION APOROVED BY MEDICAL EXAMINE Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year g Unknown g 🗌 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Subdural Hematoma, Normal Pressure Hydrocephalus, Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Left Hip Fracture 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? certificate 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury
September and
October 2011 27. Manger of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Z Natural 5 Pending Unknown Subject fell neral Director: A 2X Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) **105 Times Square** 28e. Place of Injury - At home, farm, street, factory, office Homicide determined Nursing Home Salisbury,MD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year) D 0071972 122/201 DIVISION STREET 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 1MD-21804 SuiteB, Salibury SAMEER MBDUI TAI UDDGT SHAIK 32 Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	aryland / Depa			Mental Hy	giene	
	A	m e	hdragstral 7 FH, TCHD 11/29/	11 ohaCer	tificate of l	Death	_	Reg. No. 2	11, 40396
	Physicia		1. Decedent's Name (First, Middle, Last) Oliver H.	Noy			2. Date of Dea	$24^{ m pay}/~201^{ m e}$	3. Time of Death 7:30 Р м
	Medic Examir		4a. Facility Name (if not institution, give street and number)	Tioy		r Location of Deat		4c. County of E	
		П	10303 Tuckahoe Road	Dent			Carol	ine	
	Funeral Director		5. Social Security Number 219-17-4145 6. Sex 14 M 2 \square F 7. Age	e (In yrs. last birthday) 25 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. 1986	Birthplace (State or Foreign Country)
	nd how at	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
	farylar Ba-f s tified	I Director	Md. Caroline	Den					1 ☐ Yes 2 🌠 No
	a or 2		10e. Street and Number		10f. Zip Code			10g. Citizen of What	t Country?
	th with ms 23 must	Funeral	10303 Tuckahoe Road		216			U.S.A.	
920	le 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces 1 Yes 2 1 If Yes, Give	No If	Vas Decedent of H Yes, specify Cuba	an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc. White
5-0	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occup		rkina	16b. Kind of Busin	ess Industry
21215-0036	ithin 7 ene. r than	Completed	Elementapy/Seconday (0-12) College (1-4 or 5-	life DC	NOT use retired) Farmer			Agricul	ture
and 2	uld be filed w Mental Hygi narked other latic event, t	To Be (17. Father's Name (First, Middle, Last) Henry F. Noues	Noyes		18. Mother's Na Christ	ne (First, Middle, ine A.	Maiden Surname) Seibert	
Maryland	12 should alth and Me 27 is mar r traumati		19a. Informant's Name/Relationship (Type, Print) Christine S. Noyes / Mothe					r, City or Town, State	, Zip Code) Md. 21624
Baltimore,	age 1 and ent of Heal nt: If item 3		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos	sition (Name of patory or other place	ce)	Date 6-2011	20c. Location - City Delmar,	
Baltii	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	Ph	Man eengd A&dr	etrowsk:	i Funera	1 Home P.A., Md. 2166	Α.
			23a. Part 1. Enter the disease, or complications that caused	the death. Do not enter				·	Approximate
	nysician/ Medical	i	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	cell ple	uslid	e erire	truen	cher	Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, b.	a consequence of):					
	uted d ansit		the arry, leading to immediate Due to (or as a consequence of). Cause. Enter Underlying Cause. (Disease or linjury						
	certificate be executed nding physician and use as the burial-transit		that initiated events resulting in death) Last C. Due to (or as a	consequence of):					
9	icate by physics the b	ledical	d						
X R R	death he atte ed for	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 🗌 Fetal death 3 🔲	Ectopic pregnand Other (specify)	ey		23d. Date of Month	f delivery Day Year
л Э	that th ned by e detac	by Ph	Part II. Other significant conditions contributing to death bu	at not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
ďS,	quires en sig ould be						1 🗆 🗅	∕es 2 X No 3 [Probably 4 Unknown
Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours factor death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed					24a. Was a autop perfor 1 Yes	sy prior	e autopsy findings available to completion of cause of h? Yes 2 \sum No
VITA	ician: certific ector,	Be	25. Was case referred to medical examiner?			ace of Death (Che	ck only one)		
<u> </u>	Physic ruthis or all dir	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatier 27. Manner of Death 28a. Date of injury	ent 2 ER/Outpatient y 28b. Time of	3 DOA Othe	4 L Nursing F	1	ence 6 D Other (S	pecify)
000	anding rath. r: Afte	icate	1 ⚠ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident ☐ Investigation	Year) injury	work	? Yes 2 \sum No	Zod. Describe III	ow injury occurred	
DIVISION	tal or Atte rs after de al Directo ed in by th	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, stree (Specify)	et, factory, office		28f. Location (S City or Tow		Rural Route Number,
	he Hospi iin 24 hou he Funer ipleted fill	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of machine in the basis of examiner: On the basis of examiner: On the basis of examiner: To the basis	amination and/or investi	gation, in my opinic	n, death occurred	at the time, date ar	nd place, and due to t	the cause(s) and manner stated.
	vith		29b. Signatore and title of certifier Durré Hauth M	ID	29c. License	1887		29d. Date signed (Mo	onth, Day, Year)
	5		30. Name and address of person who completed cause of dea David H. Smith, M.D. 8221 1	ath (Item 23a) (Type, Pr Ceal Drive ,	Suite 3	02 East	on, Md. 2	21601	
	Stat Registra	_	31. Date filed (Month, Day Year) 32. Regetrar NOV 2 9 2011	's Signature	San				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40397 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month 31,251 men har John Bunyan Nutwell 2D11 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BAltimore Washington Medical Center Glen Burnie ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Days Hours Min. (Month, Day, Year) 2-25-1919 Mary Land Director 216-16-4737 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Anne Arundel Deale 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 5734 Nutwell Sudley Road 20751 USA death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Specify: White injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene 6 farmer agriculture is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Fennimore Nutwell Edna Florence Sherbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Mary L. Nutwell, Spouse 4713 Henshaw Lane, Pasadena, MD20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) James' Cemetery 12-01-2011 Lothian, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rausch Funeral Home, P.A. William 8325 Mt. Harmony Lane, Owings, MD M00715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Ne Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy To the Hospital or Attending Physician: The lwithin 24 hours after death.

To the Funeral Director: After this certificate h perforn death? 1 Yes 2 No ☐ Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes Other: 1 paper 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Natural 5 \square Pending work 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and ad f person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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32. Registrar's Sanature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Iride Piccione Now 128, 2011 12:40 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Prince Frederick 4c.County of Death Calvert Memorial Hospital 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X Days Hours June 11 Year 1921 **Director** 122-24-4916 90 I Carry Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Calvert St. Leonard 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5301 Cove View Drive 20685 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H is marked of Pietro Cimolino Emma DiGiorgio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health is item 27 i Dino Piccione - son 4261 Exetor Drive Dumfries VA 22025 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 and Department of Hamportant: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Cedar hill Cemetery | Dec 3 2011 Newburgh New York ore of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home BROWSC 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine dany, leading to in mediate cause. Enter Underlying sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No 24a. Was an has autopsv page performed? Yes 2 No this certificate 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 \square Yes Other: ည 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 atural 5 Pending nours after death.

neral Director: After dilled in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifies Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only er onth, Day, Year)

Registrar
DHMH 17 Rev 7/2009

20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 40399 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Richard Wayne Paul Poffenberger, JR. 0538 Medical 4a. Facilify Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Meritus Medical Center Hagerstown 6. Sex 1 X M 2 □ F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth May1, 1960 219-66-2366 51 Maryland **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Washington County Clear Spring 1 ☐ Yes 2 X No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 11813 Big Spring Rd. 21722 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force: ori 1 Never Married 2 X Married el Hygiene.
"Ser than "natural", o 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other tl Police Officer State Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Wayne Paul Poffenberger, Sr. Dorothy L. Golden Poffenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Teresa Poffenberger-wife 11813 Big Spring Rd. Clear Spring, MD 21722 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 12-7-2011 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 22. Name and Address of Facility DouglasA. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the cisease, or complications that cause the stath. Do not enter the mode of dyin shock, or head failure. List only one cause on each line. Immediate Caus I inal Physician/ disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a cons attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death the a 9 Unknown 9 Unknown Records, P.O. s been signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an lor Attending Physician: The law after death. this certificate has ral director, page 2 prior to completion of cause of death? autopsy performed 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After the filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D 29a. Cerlific Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practiturer: To the best of my knowledge, death documed at the time, date and place, and due to the cause (s) and manner as state 29b. Signature and title of certifier 20045031. MI 30. Name and address of person who or impleted cause of death (Item 23a) (Type, Print) anhetum Smet HAG JW-10 Sipproull 324

DHMH 17 Rev 7/2009

State Registrar

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40400 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 354 M 201 Franklin <u>Pannone</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** May 15. 192 Months Days 1 QM 2 🗆 F Hours Director Yrs 90 220-10-0986 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Cumberland Allegany 1 XYes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21502 13602 Uhl Highway SE USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried þ Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced WW II white 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 CSX Railroad boilermaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ္ Maria Cuzzo Francesco Pannone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Michael Pannone MD 21502 son 11645 Mikes Lane SE Cumberland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 12/12/2011 Cumberland MD 4 Denation 5 Cher (Specify) Signature of Funeral Ser 22. Name and Address of Eacility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumones disease or condition resulting in death) BILA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed and trans that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial burial Physician/Medical attending pl IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year ed by the a g Unknown a Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 2 🗌 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: 1 🔲 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural
Accident
Suicide 5 Pending s after death.

Director: Aft 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1-🛱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 280 00033 Dec 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 1025 Kent Ave. Ste. 101 Cumberland, MD 21502 State 6 2011 Registrar

DHMH 17 Rev 7/2009

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 8 Bonnie Lou Pritchard 2011 0440 Αм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Smith Creek Assisted Living Cecil Warwick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛚 F Months Days AUG 30, Year 921 Director 90 Nebraska 564-26-6139 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 Delaware Avenue 21921 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) Cash Office Manager Retail Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Force Buchanan Lottie Lou Melick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothea J. Hepner/Granddaughter 403 Delaware Avenue, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Arington
National Cemetery December 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 19, 2011 Cemetery Arlington, VA Hicks Home for Funerals, P.A. 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ CORONARY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Pregnant at time of death Month Year cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed Yes 2 No 1 Yes B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 X Other (Specify) Living Hospital: 2 🗹 No Certificate: To 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier P. V. Name DO0 65733 MD 12/12/11 ly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RARAYARA RAVIN PULA, 124 A STREET, BCKTON, MD 21921

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

6 2011

32. Registrar's Signature

EHIGH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State amend Item 25 State of Manyand Registrar	/03/2 Cer	orent of H	lealth a Death	nd Mental Hy	giene _{Reg. No.} 20		40402
	Physicia	an/	1. Decedent's Name (First, Middle, Last)				2. Date of De	ath	Voor	3. Time of Death
	Medic	cal	Estelle Virginia Quandt				Decembe	1	011	1942M
	Examir	ner	4a. Facility Name (If not institution, give street and number) Meritus Medical Center			City, Town, or Location of Death Hagerstown 4c. County of Death Washington				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last)	birthday)	If Under 1 Year	If Under 24		th	9. Birthp	lace (State or Foreign
	Director		218-14-1662 1 M 2 X F 89	Yrs.	Months Days	Hours	Min. 8/28/12	922	Mary	Pand
	nd how at		Usual Residence of Decedent 10a. State 10b. County 10c. City, To.	own or Loc	ation			<u></u>	110	Od. Inside City Limits
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	a or 2 be no	٥	10e. Street and Number		10f. Zip Code			_	zen of What Country?	
	th with ms 23 must	Funeral	19800 Tranquility Circle		21740			U.S.A.		
' O	or iter		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	13. W	Vas Decedent of His Yes, specify Cubar	spanic Origir n, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)		e - America k, White, e	
036	rs afte Iral", (Exan	ed b	3 No Widowed 4 Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 No	Specify:		Specify:	Whi	te
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12	ithin 7 ene. r than	Con	Elementary/Seconday (0-12) College (1-4 or 5+)) NOT use retired) k Operati	one O	nerator	Comm	unica	ations
d 2	iled w	æ	17. Father's Name (First, Middle, Last)	CWOL	K Operati		's Name (First, Middle,			
ylar	ld be l Menta arked atic e	욘	Leonard Schorr			C	Catherine E	lizabetl	n Bre	yer
Maryland 21215-0036	shou n and 7 is m raums						or Rural Route Numbe			ode)
e,	and 2 s Health tem 27				Malcolm (it., A	nnandale,	VA 2200.		un Stata
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 Cremation 3 ☐ Removal from State ceme	etery, crem	atory or other place				•	
alti	permit. F Departm Importa any inju		21. Signature of Funeral Service Licensee	22.	Name and Address	s of Facility	2/6/2011 Rest Have	Smiths!	urg,	Maryland anel
<u>m</u>	9 9 T E 9		There M. Mitts	1	601 Penns	ylvan	ia Ave., H	agerstov	m. M	D 21742
			23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.			, such as ca	ardiac or respiratory arr	rest,		Approximate Interval Between
	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)		nal !	lan	now hage	/		Onset and Death
	Examiner		Due to (or as a consequence	се от):				11/1		
	- +	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	o of			111	11/, 11	4	
	ohysician and the burial-transit	xan	Cause (Disease or linjury that initiated events c	20 of:		11 1	1 Bue	MEDICAL EXAMIN	ER	· · ·
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3760	ficate g phys as the	Nedi	d			CEAL	Th. (o)			
39 ×	eath certifical attending ph I for use as th	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de		Ectopic pregnancy	/		23d. Dat	e of delive	ry
P.O. Box 687	e deat the at hed fo	by Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of deat 9 ☐ Unknown		Other (specify)			Mor	nth	Day Year
0.	es that the des signed by the a I be detached f	y Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to the	e cause of death?
_ <u>(</u> 2	requires i been sign should be	ed b					1 🗆 '	Yes 2 □ No	3 🗆 Prob	ably 4 📈 Unknown
Division of Vital Records,	aw rec as bee 2 sho	Completed					24a. Was autop		Vere autop	sy findings available appletion of cause of
Be	cate has	Con					perfo	rmed?	eath?	_
ta :	Fnysician: The r this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 To Yes Hospital:			r:	(Check only one)			
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on	Attending death. ctor: After y the funer	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury	M 1 □ Y	∕es 2□N	lo			
S :	or Attency after death Director: / d in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural I	Route Number,
	Notified in bythe foresting of Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledg	e. death or	cured at the time.	date and pla	ace, and due to the car	ise(s) and manne	r as stated	
:	ne no in 24 h he Fur pletec	Med	(Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my known	d/or investig	gation, in my opinior	i, death occu	urred at the time, date a	nd place, and due	to the caus	se(s) and manner stated.
-	Nith Com		29b. Signature and title of certifier		29c. License			29d. Date signed		
			Mayen grag		D D	2836	3	12-5-	- 71	
]'N	- 3			a) (Type, Pri	368 WI	o ito	ut-Noge	Reins	POJ V	21760
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	Registra	ir	DEC 0 5 2011 >	A	Bath					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NHOL RUSSAEK 1:00 A . M DEPEMBER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** PERRY r Location of Death MARYLAND HEALTH CARE PUINI SYSTEM 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F 0 1 Month Day gents Days 86 Newyersey Director 144-16-7807 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maruland Talbot Tilghman 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 21671 10g. Citizen of What Country? Funeral 21537 Coopertown Road United States of America 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, was beceent Ever in 0. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WW I I Year or Dates. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify "natural", Specify: Completed 3 X Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement Conservation Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Dona Krunmuna Alex Russack permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 08234 5 Princeton Road, Egg Harbor Township, New Jersey 19a. Informant's Name/Relationship (Type, Print) Michael J. Russack (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cometery, crematory or other place)
Holy Sepulchre Cemetery 12-10-2011 Hammonton, New Jersey 22. Name and Address of Facility Zcleman Funeral Home, P.A. 21078 123 S. Washingźon St., Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do 11 enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset land Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) 24 hours after death.
24 hours after death.
26 hours after death.
5 Funeral Director. After this certificate has been signed by the attending physician and attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Year Day Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t autopsy performed? Yes 2 N death? 2 🗌 No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 Yes 2 🗌 No Accident Investigation Suicide 6 [Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND HEALTH CARE SYSTEM,

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	tem 25 State of M	aryland / 12	16/2011dh Certificate of	Health and I Death	Mental Hygi Re	ene g. No. 201	1 40404	
	Physicia	n/	1. Decedent's Name (First, Mi	ddle, Last)				Date of Death Month	1-11	3. Time of Death	
	Medic		Paul	Godlove		Rodgers		December	6, 2011	9:50 A M	
	Examir	ier	4a. Facility Name (if not institu			,	or Location of Death	1	4c. County of Dea		
an again			338 Sunbrook 5. Social Security Number		a - Labert	Hagers If Under 1 Year		I a a	Washing		
	Funeral Director		218-24-1274 Usual Residence of Decedent	1 X M 2 □ F	e (In yrs. last birthda 84 Yrs	Months Days		8. Date of Birth (Month, Day, Y	1927 Ma	rthplace (State or Foreign ountry) ryland	
	a-f show ied at	Director	10a. State 10b. Cou	inty	10c. City, Town or				10d. Inside City Limits 1 1 √2 Yes 2 □ No		
	r 28a notif		MD Wash	nington	Hagerst	10f. Zip Code		1.40	g. Citizen of What C		
	ith th	교	338 Sunbrook	Lano		21742)	10	•	,	
	ems r mu	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	3. Was Decedent of I		pecify Yes or No-	U.S.A		
21215-0036	72 hours after death with the Maryland n"natural", or items 23a or 28a-f show dedical Examiner must be notified at	2	1 ☐ Never Married 2 🛣 3 ☐ Widowed 4 ☐ Divor	Armed Forces? 1 ☐ Yes 2 🔀	s? If Yes, specify Cuban, Mexican, Puerto X No 1 ☐ Yes 2 X No Specify:			o Rican, etc.)	Black, Whit		
5-0	"natu	bet		edent's Education ighest grade completed)	16a. De	ecedent's Usual Occu ive kind of work done	pation	kina 1	6b. Kind of Business	Industry	
121	e filed within 72 hour ital Hygiene. ed other than "natu event, the Medical	Completed	Elementary/Seconday (0-1		ife	e. DO NOT use retired		narig	0		
2	filed within al Hygiene.	Be C	17. Father's Name (First, Midd	(lo Lost)	Iru	ck Driver	I		Construc	tion	
anc	be file ental I ked o ic eve	To E	Sydney Vance					_{ne (First, Middle, Ma} nn Galien	·		
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<u>6</u>	f Hea item othe		20a. Method of Disposition		20b. Place of Di	sposition (Name of	1		0c. Location - City or		
Baltimore, Maryland	Page 1 nent of ant: If it ury or o		1 X Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Oth	ion 3 Removal from State		crematory or other pla ven Cemet			lagerstown		
alti	400		21. Signature of Funeral Servi	***	1.000 110	T-4			Funeral		
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	Physician/		shock, or heart failure. L Immediate Cause (Final disease or condition	e, or commit ations that caused ist only one cause on each line	ð.	21		or respiratory arrest	.,	Approximate Interval Between nset and Death	
-	Medical Examiner		resulting in death)	Due to (or as	a consequence of):	descare				,	
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ő	eath certifice attending p for use as t	an/l	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 ☐ Ectopic pregnar	ICV		23d. Date of de	alivery	
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Secol	he law re te has be age 2 sh	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of	
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₹	hysic nis ce I direc	2	1 ☐ Yes 2 💢 No	Hospital:	ent 2 🗆 ER/Outpa	tient 3 DOA Oti	ner: 4 Nursing H	lome 5 Residen	ce 6 Other (Spe	cify)	
on of	ath. ath. nr. After the ne funeral			estigation	ry 28b. Time (, Year) Injur	y wor		28d. Describe how	injury occurred		
Division of Vital Records, P.O. Box 68	to the Hospital or Attendating Physician; The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a			ermined 28e. Place of Injubulding, etc		street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,	
:	he Hospi iin 24 hou he Funer ipleted fill	Medical	(Check 2 L Medic	ring Physician: To the best of al Examiner: On the basis of e ring Nurse Practioner: To the	kamination and/or in	vestigation, in my opin	ion, death occurred	at the time, date and	place, and due to the	cause(s) and manner stated.	
	Note that the state of the stat		29b. Signature and title of cert	u gneel		29c. Licens	se number D 283 65	29	d. Date signed (Mont	th, Day, Year)	
	10		30. Name and address of pers	on who completed cause of de the state of th	eath (Item 23a) (Typ	e, Print)	ul-Herp	Sherry r	902174	υ	
H	Stat Registra	_	31. Date filed (Month, Day, Yea	3 2011 33/ Registra	r's Signature	backer					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Elnora Annette 8:32 PM Scott 2011 11 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 23946 Holsinger Lane Ridgely Caroline 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2**X** Months Days Hours 221-34-2996 Director 62 12-19-1948 Delaware Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh 1 ☐ Yes 2 No Md. Directo Caroline Ridgely the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or. ury or other traumatic event, the Medical Examiner must be I 23946 Holsinger LANE Funeral 21660 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St.Benedictine Sch. 12 Dorm Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alberta Thomas 2 Nichols Collick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Lewis Scott/Husband 23946 Holsinger Lane, Ridgely, Md. 21660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 11-26-11 Cokers Cemetery Greensboro, Md. 4☐Donation 5 ☐ Other (Specify) 21. Signature of Maneral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 717 W. Division St., Dover, De. 19904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 WKS DRCC /Medical as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mod 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the a detached f 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes Be 26. Place of Death (Check only open Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 D Residence 6 □Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Division or Vital Records,

State

Registrar

Medical

29a. Certifier

31. Date filed (Month

29b. Signature and title of certifier

NOV 28 2011

monsen Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 23

			Pleas	e Type or Pri						-		-	e.	
		_	For State	State of M	larylan	-	artment of I		and M	lental Hy		201	1 1,	01.06
			Registrar 1. Decedent's Name (First, Middle, L	.ast)		Cer	tificate of i	Death		2. Date of De	Reg. No	. 201	3. Tim	e of Death
_	sicia Iedic		Gloria	S.		S	eymour			Novem	ber	37 30	511 21	
Ex	amin		4a. Facility Name (if not institution, gi		0.5t0	n	4b. City, Town, c		of Death			County of D		
Fun Direc	ctor		5. Social Security Number 216-38-8547 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. Ia 69	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		8. Date of Bir 10-26-	th 1942	9.	Birthplace (Sta Country) Md	te or Foreign
faryland 8a-f show	ified at	ector	10a. State Md. 10b. County Talk	oot	10c. City	y, Town or Lo	cation lichaels							e City Limits Yes X No
with the N	ust be no	Funeral Director	10e. Street and Number 1108 Jefferson	Ave.	10f. Zip Code 21663						tizen of What U.	zen of What Country? U.S.A.		
Iltimore, Maryland 21215-0036 Iit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-4 show	Examiner m	þ	11. Marital Status 1 Never Married 2 Married 3 Noved 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.								14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036 within 72 hours after giene. er than "natural", o	e Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	(Give I life. D	lent's Usual Occup kind of work done O NOT use retired)	during most	t of workir	ng		Kind of Busine		
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Baltimore, Maryland oernit. Page 1 and 2 should be filled Department of Health and Mental Hy Important: If item 27 is marked oft	er trauma		19a. Informant's Name/Relationship J. Gary Seymour			al la	g Address (Street Pea Neck							
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Baltime permit. Page Department Important:	any inji		21. Signature of Funeral Service Lice	sfrowsk; C	. F. S.	e P.	Mariay Address	Ostro 18 St	wski . Mi	Funera chaels	al Ho , Md	ome P., 2166	A. 3	
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rds, P.O. Box 68760 equires that the death certificate be en signed by the attending physician in the death of deather than the deather than t	asn ioi nae	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 💆 No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3 □	Ectopic pregnand Other (specify)	су			20	23d. Date of Month	delivery Day	Year
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To the Hospital or A within 24 hours after To the Funeral Dire	nipietely	Med	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of e urse Practitioner: To th	examination the best of m	and/or invest ny knowledge,	igation, in my opini death occurred at	e, date and on, death oc the time, dat	courred at te and place	the time, date coe, and due to	and place the cause	e, and due to the e(s) and manner	he cause(s) and er as stated.	i manner stated.
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar

Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11-24-2011 Year **Physician** NORMA D. SCHUMACHER 830 A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Talbot William Hill Gardens Easton Birthplace (State or Foreign Country)
 NY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-10-1925 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 86 Months Days Hours Min. 1 □ M 2 🕶 E 213-20-1602 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminar mast be netitled at MD Talbot Easton 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 545 Cynwood Drive 21601 TISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 +School Teacher Elementary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Jey Davis Tris Louise Munn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tra once. 27 Richard A. Schumacher Jr (son) 8693 Spur Lane Easton MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Eastern Shore 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 12-07-2011 | Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) VA Cemetery 22. Name and Address of Eaclity Fellows, Helfenbein & Newnam Funeral Home, P.A. 21. Signature of Funeral Service Licensee MERCERON 200 S. Harrison St Easton MD 21601 JOHN Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final THYROID CARCINOMA POORLY DIFFERENTIATED WEEKS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 LNo Month Year 4 Pregnant at time of death Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ⚠No 24a. Was an autopsy performed certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1 Yes 2 No Certification: To 1 🖂 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of OMINGDALE AUE FEDERALSBURG, MI

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40408 FH, TCHD, State of Maryland / Department of Health and Mental Hygiene Amend LOe, State Registrar MD, TCHD, 12/1/11 pha Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11-26-2011 Kate R. Springs M 230 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 24082 Deep Neck Rd Royal Oak Talbot 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 NY **Funeral** Months Days Hours 1 □ M 2 🗓 F 5-12-1917 **Director** 103124875 94 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Talbot Royal Oak 1 Tyes 2 X No 10e. Street and Number 24082 20842 Deep Neck Rd 10f. Zip Code 10g. Citizen of What Country? Funeral 21662 USA 72 hours after death 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martin H. Rubin Frances Cohen permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. VanFossan (Personal 4240 Claylands Rd <u>Trappe MD 21673</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Chesapeake Cremation 11-28-2011 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD 21. Signa of Find al Sovice Lin Pellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St Easton MD 21601 23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on earths. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician hronic Estructive Pulmenon Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (bride a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deat
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Yes 2 🗆 No 3 🗆 Probably 4 🗆 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy perforn 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2. only one Certifying Nursa Prantiager: To the best of my linewisdow de 29b. Signature and title of certifier November 28, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynwood 20 1. enton 31. Date filed (Monti egistrar's Signatur State 29 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 40409 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1 2 Mary E. Slackway 2011 9:16 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil Union Hospital E1kton If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Days 1 M 2 X F Months Hours Min 9/23/1920 **Director** 197-07-6752 PA Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 148 S. Tartan Drive USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. o Completed by 1 Never Married 2 Married Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any hiury or other traumatic event, the Medical Exar once. If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Meat Packer Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Michael J. Garrity Mary Jane Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Walters - daughter 148 S. Tartan Drive, Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 12/6/2011 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home, PA Rising Sun, MD I Service License 22. Name and Address of Facility R.T. Foard Funeral Home, PA 259 E. Main Street, Elkton, MD 21921 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Sartic Slock Ph_sician/ disease or condition resulting in death) Medical Due to (r as a consequence of): Examiner obstruction 5 days. Small bowel Sequentially list conditions, Examine If any, leading to immedicause. Enter Underlying Due to for de a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death Unknown cate has been signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardio myo pathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown failure Christ renal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 124 hours after deat e Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) Drama 12/02/2011 D66176 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA Elkton MD 21921 MD Bow Street 106 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

parks

05

11-08776 Stacey R. Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Smith Stacey Robert Month Day November 22, 2011 **Medical Examiner** 0309 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center La Plata Charles 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) if Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Director Hours 217-06-4362 04/13/1970 41 MD Country) Yrs Usual Residence of Decedent H 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits MD Show Calvert 1 Yes 2 X No Owings Examiner must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 8780 Grover Turn Lane 20736 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 2 X No 3 Widowed 4 Divorced If Yes, Give Year Specify: Black 1 Yes 2 X No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Robert Louis Smith Brenda Wallace Be Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and I Robert L. Smith/father P.O. Box 678 Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State of I crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Young's Chr. 11/30/11 Cem. Huntingtown MD 4 Donation 5 Other Specify 22. Name and Address of Facility 22. Name and Address of Facility Sewell Funeral Home, P. 1451 Dares Beach Rd. Prince Fred., MD 21. Signature of Funeral Service Licens a. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Retween Onset and Merben Death a. Pulmonary Thrombcembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Deep Venous Thrombosis, Left leg Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physiclan/Medical UNPENDED **AMENDED** attending physician or use as the burial IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? 4 Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the Part II te to the cause of death? ğ Probably 4 🗸 Unknown Completed re autopsy findings available

Division of Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: The law requires that the death certificate be executed has page 2 s certificate this in 24 hours after ucc....
the Fuorral Director: After this

25. W ex

27. Ma

1 🗸 2

3

29a. Certifier 1

29b. Signature and title of certifie

Certification:

Medical

. Other signific	ant conditions	contributing to death bu	23e. Did tobacco us	23e. Did tobacco use contribute to the cause of death?								
						1 Yes 2 1	No 3 Probably	4 🗹 Unknown				
						24a. Was an autopsy performed?	24b. Were autops prior to comp death? 1 Ves	y findings avaitable letion of cause of 2 No				
as case referred	d to medical		26,Place of Death (Check only one)									
aminer? ✓ Yes 2	No	Hospital: 1 Inpatient	2 PR/Outpatient 3	DOA Other	Nursing	Home 5 Residence	ce 6 Other:					
nner of Death		28a. Date of Injury	28b. Time of Injury	28c. Injury at Wo	rk?	28d. Describe how injury	occurred					
Natural g	5 Pending Investiga	(Month, Day, Year)		1 Yes 2	No							
Suicide 6 Could not be determined		be 28e. Place of Injury	 Location (Street and Number or Rural Route Number, Cit or Town, State) 									

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

Within 7

29d. Date signed (Month, Day, Year)

November 22, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Month Year 2000 Decembe Charlotte Faye Snyder Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Min. 3/30/1925 Hours **Director** Maryland 86 219-12-2398 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene. Of Health and State Hygiene. If item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be nother traumatic event, the Medical Examiner must be. Funeral 18804 Rolling Road 21742 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 ₩Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic : should be filed witl n and Mental Hygier 7 is marked other t Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Weinstein Maurice Aaron Weiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joel Snyder / Son 906 Pontiac Ave., Frederick, MD 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or ō cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/10/2011 | Hagerstown, Maryland Rest Haven Cemetery 22. Name and Address of Facility REst Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami The law requires that the death certificate be executed that initiated events and -tran Due to (or as a consequence of) resulting in death) Last burialphysician s the burlal Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? certificate 1 Yes 2 No To the Hospital or Attending Physician: æ 25. Was case referred to edical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \(\subseteq \text{Yes} \quad 2 \(\subseteq \text{No} \) 1 Natural iniury 5 Pending s after death.

I Director: Aff
d in by the fur Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical

State Registrar

29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO istrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21-OAKHIL AVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, 6923,1/11/2012,WS

State of Maryland Thepartment of Health and Maryland Thepartment of Health and Maryland Thepartment of Death

Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month Physician/ 1:10 Shirla Louise Scott Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. Social Security Number 1928 Funeral 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F 83 (Month, Day, Year) Hours Min Maryland Director Jan. 217-30-7392 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 ី No Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 17000 Shepherdstown Pike 21782 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Completed by 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Physical Education Teacher Education/School Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic encountries. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fisher Edgar Line Clara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17000 Shepherdstown Pike Sharpsburg, Maryland 21782 Roy A. Scott (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔏 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12-3-2011 Sharpsburg, Maryland View Cemetery Signature of Funeral Service 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 2a 1. Effer the liseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ trDIOGENIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ESPIRATORY Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURE Completed 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsy 1 Yes 2 No Yes After this certification funeral director, p or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify, Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner stated.

Certifying Nurse Leadings, I. the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Leadings, I. the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) chh D0066092

JW-10 | State

Registrar
DHMH 17 Rev 7/2009

MEDICAL

CAMPUS DE.

ND

HAGERSTOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

MEHBOOB

SALMAN

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 for State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year Physician/ 3:00 PM November Medical 4a. Facility Name (if not institution, give street, and number) 4b. City, Town, or Location of Death Examiner Jary IGNA MEN If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 579-70-8515 معاديدا بحوص 1 □ M 2 🗽 **Director** -12-1952 or 28a-f show 10d. Inside City Limits Town or Location other traumatic event, the Medical Examiner must be notified at Director GNO 1 Fres 2 No 10f. Zip Code items 23a Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Kobert W.Smith SQV GNHah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is any injury or other SUNTEND WO 20746 20b, Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) averacle 26/UC 12-9-2011 Kivandate MD 22. Name and Address of Facility WISCMCH FUNERCI HENC 152701d Hoxandure Ferry Rd Clinto MD 20135 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Collapse Physician/ Cardiopilmonary disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Advance Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Abdomind Pac 24a. Was an autopsy performed? 1 Yes 2 No has page 2 this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20769 mos Glen Dole FICKZO Ste 200 12150 Annapolis Rd 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November 26, 2011 Physician/ 6:18 am Kitty Ε. Shaw Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 579-52-0694 Director 1 □ M 2X F Yrs July 31,1938Virginia Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10a. State 10b. County death with the Maryland Director notified Md Montgomery Wheaton 1 🔀 Yes 2 🗌 No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ö ms 23a or Funeral 11901 Georgia Ave 20902 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, "natural", or iter edical Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify:Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Payroll Technician the HUD 2yrs permit. Page 1 and 2 should be fileo Department of Health and Mental Hy, Important: If item 27 is marked any injury or other termone. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Maclin Jasper D. Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Shaw (Son) Panorama Drive Oxon Hill, Maryland 20745 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stat Clinton Maryland cemetery, crematory or other place)
Ressurection Cem Dec 07,201 4 ☐ Donation 5 ☐ Other (Specify) 20019 22. Name and Address of Facility 21. Signature of Fun Tyrone J. Young 5635 Eads Street NEWashDC 23a. Part 1/Enter the disease, or complication shock or heart failure. List only one cau Immediate Cause (Final o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death obstructive pulmonary disease Physician/ Chronic disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence oi) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕇 Unknown Pulmonary embolism Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dementia 24a. Was an autopsy performed? Yes__2 AN 25. Was case referred to medical Be 26. Place of Death (Check only one) Division of Vital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 🗌 유 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate; 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Fune

completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ketel Japanti 00 52 586 20/1

State Registrar Patel Japanti 1500 Forest Glen Road SilverSpring Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 050 Dorothy Marie Sandford 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** VICOM 54413641 KEGIONAL rdical If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 57 217-64-3618 Maryland **Director** 1 🗆 M 2 🗶 F 01/01/1954 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State event, the Medical Examiner must be notified at Director 1 XYes 2 No Maryland Wicomico Pittsville 10g. Citizen of What Country? 10e. Street and Number 0 Funeral 21850 USA items 23a 34732 Poplar Neck Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. o þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Paul E. Johnson Faylaine Piper other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 34732 Poplar Neck Rd., Pittsville, MD 21850 David Sandford/Spouse Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) οţ Page 1 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Pittsville Cemetery | 11/30/2011 Pittsville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service I Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD_21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one eause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury a consequence of burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending above completely filled in by the financial discourse. P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? <u>1</u>01. 2 No 1 Tyes 1 Inpatient 2 KER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural iniury work? 5 Pending 1 🗆 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 11-23-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. SALISBURY MO 100 E gistrar's Signature State Registrar

State of Maryland / Bepartment 69 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ $20\overset{\text{Year}}{1}$ 5:30 Slayton Bassetti Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Village at Harbor Pointe Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 7-20-1916 1 □ M 2 🗓 F Alabama Director 253-32-0326 Usual Residence of Decedent 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant if ifem 27 is marked of other than "natural", or items 23a or 28a-f sho ant if item 27 is marked of other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No MD Salisbury Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 611 Tressler Drive 21801 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates. Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) 12 College (1-4 or 5+) Georgia Power Company Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Rassetti Carrie Hermann Celenstino Antonio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jack R. Slayton, Jr. - Son Broadleaf Drive, Parsonsburg, Maryland 21849 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Crematory of Delmarva 11-28-2011 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bounds Funeral Home Main Street, Salisbury, Maryland 21804 705 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ inger Twe disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury attending physician and I for use as the burial-transil The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atte should be detached for Month Year Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work? 5 \square Pending 2 🗌 No Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practiciner: Tell a best of my moral dge, death occurred at the time, date and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 2180 1 Mame and address of per who completed cause of death (Item 23a) (Type, Pri Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Kathleen Searcey Nov. 24, 2215 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Delmar Manor Assisted Living Delmar If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y. Nov. 10, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Days Months Hours Min. Director 218-20-8070 85 Delaware 1926Usual Residence of Decedent 28a-f show 10a. State notified at 10c. City, Town or Location 10d, Inside City Limits Director MD Wicomico Delmar 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral 13 W. Elizabeth Street 21875 U.S.A. items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 K No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: 3 XX Widowed 4 □ Divorced Specify white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Food Service 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Catherine Mitchell William J. Elliott, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delmar, DE 19940 Robert J. Searcey (grandson) 206 N. 10th Street 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Stephens CemeteryNov. 30, 2011 Delmar, Delaware 21. Signature of Funeral Service Licenses Name and Address of Facility Short Funeral 13 East Grove Home Street Delmar, DE 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -ADDAM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of down. 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death signed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has be lirector, page 2 s autopsy performee 1 Yes 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Hospital e 🗆 No ည 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate (Month, Day, Year) Natural 5 Pending s after death. Accident 1 Tes 2 No Investigation the To the Hospital or Atte within 24 hours after der To the Funeral Director completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie POTO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) would no 1180 152 State

DHMH 17 Rev 7/2009

Registrar

Division of Vital

1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>1,</u> Month Physician/ Helyne Carmine Stephens November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 6442 Quantico Road Wicomico Hebron 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min 221-12-8899 Usual Residence of Decede **Director** 1 M 2 🔀 F 04/18/1925 86 28a-f show items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21830 6442 Quantico Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian "natural", or iten edical Examiner r Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. Elementary/Secondary (0-12) within 7 College (1-4 or 5+) Banker Banking and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Florence Ollie E. Carmine Page 1 and 2 should I ment of Health and Mr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Myrna Enlow/daughter PO Box 301, Mardela Springs, MD 21837 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parsons Cemetery 4 Donation 5 Other (Specify) Salisbury, MD 11/28/2011 nature of Funeral Service Licensée Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 1. Enter the disease, or complications that cause ock, or heart failure. List only one cause on each lin the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final AICUD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 use as attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death should be detached P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ The law requires Records, Completed 24a. Was an autopsy performed? Yes 2 No page 2 certificate • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific filled in by the funeral director, 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 Pending work?
1 Yes 2 No Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continued by the cause of the completely To the within 2 only one 29b. Signatu 1+50497 me and address of p pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 11/22/11 Salohy MD 21801

40418

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1 Tes 2 X No

Delaware

White

0650 M

DME

O. ((

100 Ecarroll St.

State of Maryland / Department of Health and Mental Hygiene 20 | | 1 - State Registrar wchd-te-11/20e/tificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 9:15 A M Darlene Lewis 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 9826 Sharptown Road Mardela Springs If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 □ M 2 👿 F (Month, Day, Year) 08/02/1951 218-58-0736 60 Director Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director injury or other traumatic event, the Medical Examiner must be notified 1XXYes 2 No Wicomico Mardela Springs 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21837 9826 Sharptown Road Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Bace - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ŏ ģ 1 Never Married 2 XXMarried ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XXVo Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "n (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Homemaking Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve ည Adeline Zabitakis William E. Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing**திந்து நிர்கு நரி** Number or Rural Route Number, City or Town, State, Zip Code) 9826 Shearptown Road, Mardela Springs, MD 21837 Scott L. Smith 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State Parsell Funeral Homes 4 Donation 5 Other (Specify) 11/23/2011 Lewes, Delaware Crematorium 21. Signature of Juneral Sep 22. Name and Address of Fairly Parsell Fune at Homes & Crematorium 16961 Kings Highway, Lewes, DE 28a. Par 1. Enter the discook, or heart four or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Interval Between nmediate Cause (Fin Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any least sequentially list sequentially li Due to or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-t Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 onths? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? No No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending s after death. M Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital or within 24 hours at To the Funeral D Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the beet of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signatur 80 BOX 1733 SALISBURY, MD 21862 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID COURL 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital Records,

cian/	1. Decedent's Name (First, Middle Michael De	, Last) an Shambur	ek	301	tificate				2. Date of De Month Novemb	ath Day	201 1, 201	3. Time of 2:47	f Deat
dical niner	4a. Facility Name (if not institution, 5545 Royal Mil				4b. City, 7		Location	of Death	110 V Child	4c. C	County of Death	h	
al or	5. Social Security Number 395–50–9884 Usual Residence of Decedent	395-50-9884 1x1 M 2 □ F 61						If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. 11/30/			Day, Year) Count		r Foi
Funeral Director	10a. State 10b. County Maryland Wico	mico	10c. City,		vn or Location alisbury							10d. Inside Ci	-
neral [10e. Street and Number 5545 Royal M	ile Blvd.			10f. Zip	Code 1801				-	en of What Co	untry?	
þ	1 Never Married 2 🕱 Marı	If Vee Cive		10 M						4. Race - Ame Black, White pecify: Wh			
Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4 or 5	+)	(Give I life. D	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry Hudson Health Se			
To Be C	12 17. Father's Name (First, Middle, L Lloyd W. Sha	,		Presi	.dent/	18. Mother's Name (First, Middle, Maiden Surname) Carol Geniesse					.cii ber		
	19a. Informant's Name/Relationsh Joy L. Shambure				bb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 5545 Royal Mile Blvd, Salisbury, MD 218								
	20a. Method of Disposition 1 ☐ Burlal 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S		ce	ace of Dispo metery, cren isbury	natory or ot	her plac			Date 23/2011		ation - City or isbury,		
ouce	2. Signature of Funera Strice	Borroson	a	-se 5	Name and Ollow	Addres Ay E	uner uner	ăl He	ome Pro Salisb	fessi	onal A MD 218	ssociat 04	.ic
n/ al er	23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	complications that caused inly one cause on each line a. Due to (or as a		V	er the mode		g, such as	cardiac d	or respiratory ar	rest,		Approximat Interval Bet Onset and	wee Dea
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):												
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown							23d. Date of delivery Month Day Ye			Year	
5	Part II. Other significant condition	ons contributing to death be	ut not resul	Iting in the u	nderlying c	ause giv	en in Part	1.				the cause of c	
Completed		- good - C.							24a. Was	an	24b. Were au prior to death?	topsy findings completion of c	avail
	25. Was case referred to medical examiner?	Hospital:					Dr.		k only one)				_
Be	examiner? 1 No line in a l											ify)	
To Be	2 Accident Investigation 3 Suicide 4 Homicide determined Suicide determined Suicide A Suicide determined Suicide Suicide determined Suicide Suicide A Suicide									vn, State)		ral Route Numb	er,
Certificate: To Be	3 Suicide 6 Could	building, etc	29a. Certifier (Check 2 Medical caminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
ertificate: To Be	3 Suicide 6 Could 4 Homicide determ 29a. Certifier 1 Certifying (Check 2 Megical B	Physician: To the best of examiner: On the basis of examiner: To the	camination :	and/or invest	tigation, in n death occu	rred at the	n, death o	ccurred a	t the time, date a	and place, a the cause(s)	and due to the	cause(s) and ma is stated.	anne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:13AN Robert Lee Thomas Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WICOMICO REGIONAL If Under 24 H/s 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Country) 75 Director 221-22-3844 1 🛛 M 2 🗆 F 08/30/1936 Delaware Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 □ No DE Sussex Bridgeville 6 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral within 72 hours after death with 19933 USA 103 Sussex Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 😾 Married by 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Auto Parts than, I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Distributor Delivery Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental | 2 Charles N. Thomas Florence Elizabeth Russell 1 and 2 should **k** f Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 103 Sussex Ave., Bridgeville, DE Mary Louise Thomas / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If its any injury or ot 1 X Burial 2 Cremation 3 Removal from State Bridgeville Cemetery 11/27/2011 Bridgeville, DE ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility
Parsell Funeral Homes & Crematorium
202 Laws Street, Bridgeville, DE 19933 ith basell Massel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ALUTE ANTERION disease or condition resulting in death) 415 Medical Due to (or as a consequence of) Examiner ASLVA Sequentially list conditions Examine if any, leading to immediate cause, Enter Underlying Due to (or as a consequence of): physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as the b IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death signed by the aid be detached for 1 ☐ Yes ∠ ☐ g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 🔀 No 욘 1 Na Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geaun occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one) 29b. Signature and title of certifier 29c. License numbe 29d Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 06-2011

100E Carroll St. Sklisbury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

Dennis Chodnicki

0209

, md. 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40422 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ NOVEMBER 22, 2011 GEORGE MCNEER WOODWORTH 10:03A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death FREDERICK FREDERICK MEMORIAL HOSPITAL Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min 1 🔀 M 2 🗆 F 234-38-8874 West Virginia T927 **Director** Dec. Usual Residence of Decedent or 28a-f show notified at e filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 313 Adam Road 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give WWII Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Antique Automobiles Automobile Restorer Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Esther McNeer David Woodworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Smithfield Dr., Middletown, MD 21769 19a. Informant's Name/Relationship (Type, Print) George D. Woodworth / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 26, 20c. Location - City or Town, State cemetery, crematory or other place)
Restnaven
Memorial Gardens 1 🖾 Burial 2 □ Cremation 3 □ Removal from State Nov. 2011 Frederick, Maryland 4 Donation 5 Other (Specify) Signature Frineral Servi Licensee Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. Part 1. Enter the disease, shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ na disease or andition resulting in death)) Medical Examiner Sequentially list conditions, Examine if a y, leading to in nodiate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a sor or Attending Physician; The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy performed' death? within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page Yes 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e, nova 'Ye 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400

Registrar

State

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 29, Mary Margo Williams-McSwain November 2011 2100 hrs. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months June 7, 1955 578-78-2042 1 M 2 X F Days Hours Min. **Director** 56 Washington, D.C Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Montgomery Silver Spring 1 X Yes 2 No the 10f. Zip Code 10g. Citizen of What Country? 13413 Cedar Creek Lane 20904 United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: **Black** 3 Widowed 4 X Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pediatrician Medical Doctor 12 years Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Larry Calvin Williams Theresa Biagas 19a. Informant's Name/Relationship (Type, Print) (Father) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Attorney Larry C. Williams 1451 Jonquil Street, N.W.; Washington, D.C. 20012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec.3,2011 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland Signature of Funeral 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Cardiac Arrest Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Anoxia Encephalopathy tran Due to (or as a consequence of) physician a the burial-1 resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy5 Other (specify) Month Day Year Pregnant at time of death ned by the a detached f 9 Unknown 9 XUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be c 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 1 Yes 2X No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 🗶 No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred XNatural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year 29c. License numbe November 30, 2011 D55475 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gebremedhin Yohannes, M.D.; 1500 Forest Glen Road; Silver Spring, Maryland 20910 32. Registratis Signatura State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011

			For State Registrar	State of Maryla	ind / Depa Cei	artment of H tificate of D	ealth and M eath		ene 20	11 4042	
	Physicia		Decedent's Name (First, Middle, Last, Norman Howard	Whiteley				2. Date of Death Month	Day	3. Time of Death	
	Medio Examir		4a. Facility Name (if not institution, give s			4b. City, Town, or I		November	25 2 4c. County of	011 2:00 PM	
	Exami		Wicomico Nursing			Salis			Wico		
	Funeral Director		5. Social Security Number 212–38–1742 6. Security Number 1 9 1 9 1 9 1 9 1 9 1 9 1 9 1 9 1 9 1	7. Age (In yrs 71 7. Age (In yrs 71 71 71 71 71 71 71 71 71 71 71 71 71	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye)	340	9. Birthplace (State or Foreign Country) Maryland	
	faryland Ba-f show tified at	ector	10a. State 10b. County Maryland Wicomic		City, Town or Lo				10d. Inside City Limits 1 ঁ Yes 2 □ No		
	with the N s 23a or 2 ust be no	Funeral Director	10e. Street and Number 900 Booth St.			10f. Zip Code 21801		109	g. Citizen of Wh	nat Country?	
3036	permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fleem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	'	Mas Decedent of His f Yes, specify Cuban I ☐ Yes 2 🛣 No	, Mexican, Puerto	cify Yes or No- Rican, etc.)	Black,	- American Indian, White, etc. White	
21215-0036	thin 72 hou sne. than "nat he Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give	dent's Usual Occupat kind of work done du O NOT use retired) Vall Contr	ıring most of worki	ng 16	Const	·	
land 2	I be filed wi fental Hygie rked other tic event, ti	To Be (17. Father's Name (First, Middle, Last) Dorsey Howard Whit	<u> </u>			18. Mother's Name	e (First, Middle, Mai a Dempsey			
, Mary	d 2 should alth and Me 27 is mar ir traumati		19a. Informant's Name/Relationship (Type Dawn E. Llinas/da	aughter	19b. Mailir 611 I	ng Address (Street ar Lakeside D	nd Number or Rura Dr., Sali	l Route Number, Ci sbury, M	ty or Town. Sta 21801	ite, Zip Code)	
Baltimore, Maryland	. Page 1 ar ment of He tant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Removal from State		sition (Name of natory or other place, 7 Cremator) [c. Location - C	City or Town, State	
pair	permit Depart Import any inj once	1	Nova 7. 6	empro C	75P 7	HOTTOWAY TO SOL Snow H	dheral H Hill Rd.,	ome Profe Salisbu	essiona cy, MD	l Association 21804	
	nysician/ Medical Examiner	r	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	ications that caused the de e cause on each line. a. Due to (or as a conse	A	er the mode of dying,	, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death	
3	hysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inique) that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.								
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	been signed the should be detailed	þ	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the u	nderlying cause give	n in Part I.	1 🗆 Yes	2 □ No 3	ute to the cause of death?	
ii necolus,	certificate has b	e Completed	25. Was case referred to II, rical			26 Plea	ce of Dea Check	24a. Was an autopsy performe	d2 prid	ere autopsy findince available or to completion of cause of ath? Yes 2 No	
מו אונמו	this certific al director,	To Be	ovaminor?	ospital;	☐ ER/Outpatier	Other		me 5 Residenc	e 6 🗆 Other	(Specify)	
•	within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Certificate:	27. Mann- of Death 1 Valural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury		es 2 No	28d. Describe how	injury occurred		
DIVISION	Funeral Direction of the Control of		4 Homicide determined 29a. Certifier 1 Certifying Physic	28e. Place of Injury - At I building, etc. (Special contents)	ify)	•		City or Town, S	itate)	or Rural Route Number, as stated.	
-	in 24 } he Fui	Medical	(Check 2 Medical Examin	er: On the basis of examinati Practioner: To the best of	on and/or invest	igation, in my opinion	, death occurred at	the time, date and p	lace, and due to	o the cause(s) and manner stated	
	within 2 To the I comple		29b. Signature and title of certifier	mi		29c. License r	number S/S	29d	Date signed (/	Month, Day, Year)	
ĺ	(U		30. Name and address of person who co Mahesha Thimma	rayappa MD 9	10 Eas	,	Dr. Sali	sbury MD	21804		
	Stat	te	31. Date filed (MorNOV, Year) 201	32 Registrar's Sign	atur	del		-			

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Marylan		tificate of <i>E</i>		vientai my	Reg. No. 2	2011	40426	
	Physicia		Decedent's Name (First, Middle, Lass Betty Louise					2. Date of Dea Month Novemb	ath		3. Time of Death 5:48 a ^M	
-de	Medic Examir		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death Wicomico			
Tree	Funeral		614 Bowman Driv 5. Social Security Number 6. Se		st birthday)	Salisk	If Under 24 Hrs.	8. Date of Birt		g. Birthp	place (State or Foreign	
100	Director		023–24–5951 Usual Residence of Decedent	□ M 2 🔀 F 80	Yrs.	Months Days	Hours Min.	(Month, Day 05/03/		Mas	sachusetts	
	show d at	tor	10a. State 10b. County		, Town or Lo		<u> </u>			1	0d. Inside City Limits	
	e Mary r 28a-f notifie	Director	Maryland Wicomic 10e. Street and Number	o Sa	lisbur		-		10 011		1 Yes 2 No	
	with the	Funeral [614 Bowman Drive			10f. Zip Code 21804	4	10g, Citizen of What Cou USA			itry ?	
	r items iner m	/ Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces?	If Yes, specify Cuban, Mexican, Puer			' (Specify Yes or No- uerto Rican, etc.)		Race - Americ Black, White,		
036	ırs after ıral", o I Exam	ed by	3 X Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates.	No 1 ☐ Yes 2 🗷 No Specify:				Spe	ecify: Wi	nite	
15-0	72 hou n "natu Medica	Completed	15. Decedent's E (Specify only highest gra	ade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired)			king	16b. Kind	of Business/Inc	dustry	
212	within /giene. ner tha t, the l	e Cor	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Lawy				Lav			
land	d be filed Aental Hy Irked ott tic even	To Be	17. Father's Name (First, Middle, Last) Irving Lewis Spea	r			18. Mother's Nan Thelma	ne (First, Middle, a Blanch				
, Mary	id 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (7) Susan A. Whitmore		Daughter 3008 Westcott St., 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory							
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amp injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Other (Specification)	Removal from State				Date		tion - City or To		
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P.0	s that the	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause giv	ven in Part I.			acco use contribute to the cause of death?		
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o uc	ath. r: After ne fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work		28d. Describe h	iow injury of	ccurrea		
Division of Vital Records,	Hospital of Attending 24 hours after death. Funeral Director: After stely filled in by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At ho building, etc. (Specify,		eet, factory, office		28f. Location (S City or Tov		lumber or Rura	Route Number,	
-	In the Inspiratory of Authoring Prystoran: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check 2 Medical Exami	sician: To the best of my knowl iner: On the basis of examination se Practitioner: To the best of m	and/or invest	tigation, in my opinio	on, death occurred	at the time, date a	and place, an	nd due to the ca	use(s) and manner stated.	
	ro the within 2 To the comple		29b. Signature and tale of certifier			29c, License		>	29d. Date s	signed (Month,	Day, Year)	
	51C		30. Name and address of person who deffuge was	completed cause of death (Item	23a) (Type, F	733	584(2 SAUS B	rfly	ug	21	802	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	the second		,				
DHM	H 17 Rev 06-		45	1 marine and	- 47		·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Royal Sinclair Widgeon Jr. A 9:10 2011 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death licomi If Under If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 92 Months 08/02/1919 213-12-5823 1 XM 2 - F Virginia Director Usual Residence of Deceden 28a-f show with the Maryland ms 23a or 28a-f shor must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 21804 USA 343 Cedar Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces? Black White etc 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White "natural", Specify: Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Royal Sinclair Widgeon Sr. Marv Arnett 19a. Informant's Name/Relationship (Type, Print)
Christine C. Wolff/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 206 Fawn Dr., Salisbury, MD 21804 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/25/2011 Salisbury, MD Salisbury Crematory . Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 21 Compror 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ DIOMYOPA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter on denying Cause (Disease or iinjury Examine Due to (or as a consequence of): nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Honknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy performed2 Yes 2/ 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes HOSPICKE 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manger of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury 24 hours after death.

Funeral Director: After (Month, Day, Year) Natural 5 Pending work? 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 7/2009

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32, Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Evelyn White Youngblood 3:15 P M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Golden Living Center Frederick If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month, Day Year) 24 **Director** 117-14-3804 1 🗆 M 2 😿 F 87 Yrs Usual Residence of Decedent and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10a, State 10d. Inside City Limits within 72 hours after death with the Maryland Director Frederick Frederick MD 1 XYes 2 No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21703 5656 Crabapple Ct. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) municipal Elementary/Secondary (0-12) College (1-4 or 5+) tax collector government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Edson White Martha Rodgers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford Youngblood Jr. (Son) 104 Larch Lane, Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Buria 2 ☐ Cremation 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematery11/28/2011Smithsburg, any in ²² Name and Address of Facility ompson Funeral Home Middletown, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE Ph sician/ orenno THERO SCLEROSI disease or condition resulting in death) Medical Examiner EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to joi as a consequence of Physician/Medical Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death account of the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 47951 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Toll House Ave. Theoenick, 814 A-KAZMI MO 31. Date filed (Month 32. Registrar's Signature State vacks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Pauline D. Blankner 12:05 PM December 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Carroll Lutheran Village Westminster If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Ye Dec 22 Birthplace (State or Foreign Country)
 T7 A **Funeral** Hours Min 1 M 2 1 F **Director** 99 220-34-5339 ľ911 VA Usual Residence of Deceden show . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.

Hant: If item 27 is marked other than "natural", or items 23a or 28a-f sho into rother traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 St. Luke Circle 21158 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: white Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) office management administrative assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Hoover Driver Sarah Hagerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Ann Driver (niece & executor) 1320 Driver Rd., Marriottsville, MD 21104 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 12-17-11 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Days Spaight Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trag Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy death? 1 ☐ Yes 2 🕅 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 24 hours after death.

Funeral Director: After 28d. Describe how injury occurred 1 X Natural 5 \square Pending 1 Yes 2 No completed filled in by the Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Sign State

DHMH 17 Rev 7/2009

Registrar

Month Physician /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 🗌 M 2 🗆 F Director 219-58-7091 60 MAY 23, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show at notified Director 28a-f MD N/A BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö ber 23a B37 S. NEWKIRK ST 21224 USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Examiner filed within 72 hours after 1 X Never Married 2 ☐ Married 1 Yes 2 1 If Yes, Give Year or Dates: 2 🔀 No Maryland 21215-0036 ö 1 ☐ Yes 2 No ρ 3 Widowed 4 Divorced 'natural" Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4 or 5+) al Hygiene. other than 10 SELF_EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fil of Health and Mental H f item 27 Is marked ott Be 0 UNKNOWN BETTY UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THERESA HEATLY-COMPANION 337 S. NEWKIRK ST BALTIMORE, MD 21224 Baltimore, permit. Pages 1 s
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date t☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAKLAWN CEMETERY 12/14/11 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC. 6224 EASTERN AVE BALTIMORE, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Atheroscheno tra disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infine list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy s certificate has been signed by the atter director, page 2 should be detached for in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes Completed 24a. Was an autopsy performed 2 Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: 1 Inpatient 2XN0 Other: 4 \sum Nursing Home 1 Yes 3 DOA မ ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) this completely filled in by the funeral 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: hours after death. (Month, Day Year) Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident 3 ☐ Suicide Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

1. Degedent's Name (First, Middle, Last,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

4c. County of Death

14. Race - American Indian

WHITE

Black, White, etc.

CONSTRUCTION

23d. Date of delivery

1 Tes

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

Month

Specify.

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Yes 2 No

N/A

State Registrar

29b. Signature and title of certified

within 2

2. Registrar's Signature 31. Date filed (Month, Day, Year) 9

30. Marne and address of person who completed cause of death (Item 23a) Type, Print)

and manner stated

Smar

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1-09366 tonald H. Britte	'n	Please Type or Print in Black				egible.	1 1 01 0
onaid ii. Diille		1- For State	•	ent of Health and Men ate of Death	itai Hygiene	201	1 4043
Physic	an/	Registrar 1. Decedent's Name (First, Middle,Last)	Certino	ale of Dealif	2. Date of De	Reg. No.	3. Time of Death
Medical Exam					Month	Day Year er 13, 2011	1400 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		4c. County of Deat	1
		7506 Lairds Way		Larksville Clan	cksville	Howard	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir			irth(MM/DD/YYYY) 9. Bir	
Director		262-64-5791 18 M 2 F 7	1	Yrs. Months Days Hours	Min. JUNE	4, 1940 Foreign	ountry) PA
		Usual Residence of Decedent					
w any			c. City, Town	or Location			10d. Inside City Limits
Maryland 28a-f show 1 at once.	ğ	MD HOWARD	CLARK	SVILLE			1 Yes 2 XXNo
r 28a	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	ntry?
with the Maryland ns 23a or 28a-f sho be poiffed at once.		7506 LAIRDS WAY		21029		U.S.A.	
ath w	Funeral	11. Marital Status 1 Never Married 2 XXMarried Armed Forces?		13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican		o- 14. Race - Amer White, etc.	ican Indian, Black,
ter de		3 Widowed 4 Divorced If Yes, Give Year	¹ 2959 −1961	1 Yes 2XX No specify:		Specify: WE	IITE
urs af tural amin	d by	15. Decedent's Education (Specify only highest grade complete	eted) 16a.	Decedent's Usual Occupation (Give	kind of work done	16b. Kind of Business/	
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	LI	during most of working life. DO NOT TIGATION CHIEF F	use retired)		
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	4 YEARS	co	MPLIANCE OF DRUG	S	F.D.A.	
5-0 iled w Hygic		17. Father's Name (First, Middle, Last)		18.Mother	's Name (First, Middle,	Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	DALE BRITTEN	Lio		JORIE KEITI		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial Hygiers in Pages. I file and I wanted there is a new Sand Sand I was a second offer than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٥	19a. Informant's Name/Relationship (Type, Print) EVA M. BRITTEN / SPOUSE	- 1	b. Mailing Address (Street and Nun 506 LAIRDS WAY			
and 2 fealth tem 2		20a. Method of Disposition		of Disposition (Name of cemetery,	Date	E, MARYLAND 20c. Location - City or	21029 Town, State
Baltimore, permit. Pages l ar Department of Hes Important: If ite		1 Burial 2 X Cremation 3 Removal from State	l .	ory or other place)	10/16/0011		
it. Partmen		4 Donation 5 Other Specify: 21. Signature of Functor Service Licensee	W. AR	UNDEL CREMATORY	12/16/2011	1	MAKYLAND
Depa Inje		98 S 42 / MOO	770	DONALDSON FUNE 313 TALBOTT AV	RAL HOME, I	P.A. EL, MARYLAND	20707
Physician		23a. Part I. Enter the disease, or complications that caused the					Approximate Interval
IMedical		failure. List only one cause on each line. Immediate Cause (Final disease a. Self-inflicted Guns	shot Woun	d of Torso			Between Onset and Death
≛xaminer		or condition resulting in death) Due to (or as a consequ					
	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions)	of):				
	in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ence or);				
\Ag\ .5	Examiner	events resulting in death) Last Due to (or as a consequ	ence of):		·		
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876 ifficate ng phy	M	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of 1 Live birth		Fetal death 3 Ectopic	c pregnancy	23d. Date of deliver	/ Day Year
ox 687 eath certific attending p	Sign	past 12 months?			, p. 1-g. 1-11-1		, , , , , ,
Bo the ar	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown					
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	b P	Part II. Other significant conditions contributing to death be	ut not resulting	g in the underlying cause given in Pa		obacco use contribute to es 2 ✔ No 3 Prot	
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cords, law requir has been s 2 should l	Completed				24a. Was	psy prior to o	topsy findings available completion of cause of
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of Vital Records, ng Physician: The law require the confidence has been si meral director, page 2 should b	Be	25. Was case referred to medical examiner?		26 Place of Death	(Check only one)		
Physical directions	은	1 Yes 2 No		utpatient 3 DOA Other	Nursing Home 5	Residence 6 🗸 Other	: Scene
ding.	ᇹ	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) Unknown	Unki	Time of Injury 28c. Injury at Work 1 Yes 2 ✓	Subject she	how injury occurred of self	
Sio Atten r deat ector by the	듛	2 Accident Investigation		rm, street, factory, office building, et		Street and Number of D	Tal Davida Niverbay City
DIVISION spital or Attendia tours after death. ueral Director: /	Certification:	Suicide Could not be		irii, street, ractory, office building, et	or Town,	Street and Number or Ru State LATKSVIII e Way, Larksville , MD	rai Route Number, City
Iospid 4 hour		29a. Certifier		ath occurred at the time, date and pla			
Division of Vital F To the Hospital or Attending Physician: within 24 hours after defector. After this certifi To the Funeral Director. After this certifi completely filled in by the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examin					
F	Me	and manner stated. 29b. Signature and title of certifier	1. 07	29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		Call Water Veed	nost	O.C.M.E.		December 13, 20	011
20	ŀ	30. Name and address of person who completed cause of deat	h (Item 23a)			1	
2	_	Victor Weedn MD JD Assistant Medical Ex	xaminer	900 W. Baltimore Street, B	altimore, MD 212	23	
		31 Date filed (Month Day Veer) 32 Periotrate (

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BRADSHAW DECEMBER Pay ,2011 SHIRLEY ARDENE 12:28P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year 8. Date of Birth (Month, Day Yo If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X ^{Year}1935 Maryland 76 214-36-1340 **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. But if item 27 is marked other than "natural", or items 23a or 28a-f show tury or orther traunatic event, the Medical Examiner must be notified at uruy or orther traunatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Frederick Walkersville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21793 U.S.A 9727 Woodsboro Pike 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) tile & College (1-4 or 5+) Elementary/Seconday (0-12) 12 farmer'supply/ carpet bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arabelle Fogle Woodrow Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9727 Woodsboro Pike Walkersville, MD 21793 Eric Bradshaw/ son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State All County Cremation | 12/15/2011 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ur 150 al Service License 22. Name and Address of Facility Hartzler Funeral Home Woodsboro, MD 21798 404 S. Main St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Situ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 27 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 MDD35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, mD 21701 My una Hee
31. Date filed (Marth, Day, Year) Nam 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

9 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Memal Hygiene 40433 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 12, 2011 1:00 p м Walter Buettner, Sr. Robert 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Howard Svkesville 12515 Howard Lodge Dr. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1952 Maryland 1X M 2 ☐ F 59 220-50-2092 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Howard Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 12515 Howard Lodge Dr. 21784 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐xNo Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Managing Partner Lawyer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) С. E. Buettner, Sr. Margaret Hellmann Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 Stout Run Ct., Catonsville, MD 21228
ce of Disposition (Name of Date 20c. Location - City or Town, State Leonard C. Buettner (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 12/17/11 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) YEARS ATHEROSCLEROTIC CARDIOVASCULAR Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of):

attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Completed by Physician/Medical

Medical Certification: To Be

Physician

/Medical

Examiner

MD

Director

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Completed

Be

Funeral

Director

item 27 is marked other than "natural", or Itams 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at

3.2 should be filed within 7 h and Mental Hygiene.
7 is marked other then "r

permit. Pages 1 and 2 sh Department of Health and Importent; If Item 27 is n any injury or other traun QDGs.

Physician

/Medical

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

fF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 Yes 2 No 9 Unknown	int	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectopi	pregnancy (specify)		2	3d. Date of delivery Month Day Year
Part II. Other significant co	onditions cor	itributing to death but not res	ulting in the underlyin	g cause given in	Part I.	23e. Did tobacco us 1 ☐ Yes 2 ū	se contribute to the cause of death?
						24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to mexaminer? 1 ☐ Yes 2 ☑ No		lospital: 1 Inpatient 2 I	ER/Outpatient 3	04		(Check only one)	G ☐Other (Specify)
	Pending nvestigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes		y occurred	
	Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, street, fac y)	tory, office	2	Bf. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier 1 Ce (Check only one) 2 Me	ortifying Phys edicel Exemi	sicien: To the best of my knoner: On the basis of examina and manner stated.	owledge, death occur ation and/or investigat	red at the time, di ion, in my opinion	ate and place, a n, death occurre	nd due to the cause(s) od at the time, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of	certifier	- MO		29c. License nur	nber 1860		e signed (Month, Dey, Year)

COWARIA LO

Registrar

State

10700 CHARTER DAINE # ZW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Register's Signature

JONATHAN FISH MG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 40434 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec 2011 MARCEL C. BAKER Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A GOOD SAMARITAN HOSPITAL BALTIMORE CITY Social Security Number 6. Sex If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Hours Min. (Month, Day, Year) Country) 213-32-2601 Usual Residence of Decedent **Director** 1 □ M 2**X** F 7/23/1921 MARYLAND Yrs 90 or 28a-f show 10a. State 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location Director notified at 1 Yes 2 XNo MD BALTIMORE TOWSON 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ritems 23a or ner must be n Funeral 1600 GLEN KEITH BLVD. 21286 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: WHITE "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) health care nurse vears other other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည JOSEPH COLLINS Page 1 and 2 should be MARY ZELLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a CHARLES D. BAKER, SR./HUSBAND 1600 GLEN KETTH BLVD. TOWSON, MD 21286 t of Healt Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department o Important: If any injury or 0 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 12/21/2011 CATONSVILLE, MD permit. 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, Signature of Funeral Service Licensee MOO217 8521 LOCH RAVEN BLVD. TOWSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial I Physician disease or condition resulting in death) Medical Due to (or a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying inding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should be 2 7100 1 Yes 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has page 2 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 I DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie completed cause of death (Item 23a) (Type, Print) Raven, Baltimore, Manyland avd 31. Date filed (Month, Day, State 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 40435 State of Maryland / Department of Health and Mental Hygiene

		1- For State Ce	ertificate o	f Death		Re	g. No.			
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) James Cunningham				2. Date of Death Month December	Day Year	3. Time of Death 1849 hrs		
		4a. Facility Name (if not institution, give street and number) 7549 Berkshire Road		4b. City, Town, or Loca Dundalk	ation of Death		4c. County of Baltimore			
Funeral Director			last birthday) 19 Yr	Months Days	f Under 24Hrs. Hours Min,	8. Date of Birth		9. Birthplace (State or Foreign Country) MD		
Maryland 28a-f show any d.at.once.	or	MD Baltimore	y, Town or Loca Di	undalk				10d. Inside City Limits 1 Yes 2 No		
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Director	10e. Street and Number 7549 Berkshire Road		10f. Zip Code 21224		10	10g. Citizen of What Country? USA			
5 P B	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced of Fyes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1	as Decedent of Hispani Yes, specify Cuban, Me Yes 2X No sp nt's Usual Occupation (exican, Puerto P	tican, etc.)	White,	White		
2	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 9 yrs	during n	nost of working life. DO isabled	NOT use retire	ed)	Disab			
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medical	Be	17. Father's Name (First, Middle, Last) Jimmie Cunningham			Doroth	ny Janl	kowiak			
MD 27 d 2 should lth and Mc n 27 is m.		19a. Informant's Name/Relationship (Type, Print) Dorothy Cunningham Mother	7549	ng Address (Street and 9 Berkshi	re RD	Dunda:	lk MD 2	1224		
Baltimore, ocrnit. Pages I an Department of Hea important: If iten njury or other tra	Dorothy Cunningham Mother 7549 Berkshire RD Dundalk MD 2122 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crem 12/13/11 Glen Bur									
Balt permit. Depart Import injury		21. Signature on Funeral Service Licensee 100112 Across Complete	nPA 70	90 Ri	dge Rd	& Fun Serv Hanover MD t Approximate Interval				
Physician Nacion Examiner	11	Faith. Enter the disease, or complications that caused the death faiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Complications of Huntion Due to (or as a consequence)	ington's Dis		ir as cardiac or	езрпасоту атте	st, shock, of flear	Between Onset and Death		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Due to (or as a consequence cause).	of):							
nd ransit	Medical Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence d.	of):							
760, Carate be executed physician and the burial - transit	fedica	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pre-	onancy				23d. Date of d	elivery		
Box 687 death certifine he attending d for use as t	Physician/N									
· 4 74	ā	Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause given	n in Part I.			ute to the cause of death? Probably 4 Unknown		
Division of Vital Records, P.O. Is tallor Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	Completed					24a. Was a autops perform	sy pri m <u>ed</u> ? de	ere autopsy findings available for to completion of cause of ath? Yes 2 No		
ital Reciens: The section, page	Be	25. Was case referred to medical examiner? Hospital: 1 Innation: 2	ER/Outpatien		Death (Check or	<i>,</i> ,	Residence 6	Other Seens		
ion of Virtending Physicath. tor: After this the funeral dir	ation: To	1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investigation	28b. Time of		: Work?		ow injury occurred			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At I	home, farm, stre	eet, factory, office buildi	ing, etc.	28f. Location (S or Town, St		or Rural Route Number, City		
Div To the Hospital or within 24 hours afte To the Funeral Div	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowler (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occu and/or investiga	arred at the time, date a ation, in my opinion, dea	and place, and of ath occurred at	due to the cause the time, date a	e(s) and manner a and place, and du	as stated. e to the cause(s)		
	¥	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Iter	m 23a)	29c. License nu O.C.M.E			29d. Date signed December 8	d (Month, Day, Year)		
7		Zabiullah Ali, M.D. Assistant Medical Examine	er 900 W. I	Baltimore Street,	Baltimore, I	MD 21223				
St Regist		31. Date filed (Month, Day, Year) 22. Registrar's Signa	ture Saux							
DHMH 17 Rev 1/2	001	Julius 1	ORIGINA	AL				OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12/17/2011 Physician/ Mary Catherine Carneal 3:25 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 8. Date of Birth (Month, Day, Year) 12/21/1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 212-01-1863 Director 1 🗆 M 2 🕱 F MD Usual Residence of Deced show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director injury or other traumatic event, the Medical Examiner must be notified 28a-f MDBel Air Harford 1 Yes 2X No 10e. Street and Numbe items 23a or 10g. Citizen of What Country? Funeral 1310 Sheridan Place Unit 309 21015 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Ь þ 1 Never Married 2 Married 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Homemaker Own Home is marked other Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Schultz Mary E. McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Carneal- Daughter 1310 Sheridan Place Unit 309 Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Mem'l Park 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/21/2011 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si net re of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 610 W. MacPhail Rd.Bel Air, MD 21014 Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final Onset and Death Physician. lertora TRO disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 0 week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last the burial-trans Due to (or as a consequence of) Be Completed by Physician/Medical use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the ail P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypo ension Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hai 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🖼 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ပု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending work? 2 Accident 2 🗌 No 24 hours after death Funeral Director: Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Internal Medicine 29c. License number 29d. Date signed (Month, Day, Year) D66136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPPER CHESAPEAKE DRIVE BEL AIR MD 21014 31. Date filed (Month, Day, Year) 2. Registrar's Sig 9 Registrar

ZSAM

Kenneth Richard Chamblin
11-09110 Please 1

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State of Maniford / Department of Health and Montal Hygians		

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Physicia	an/	Registrar 1. Decedent's Name (First, Mid	dle,Last)		Jeruno	ale or i	Jean		2. Date of De		3. Time of Death		
Medical Exami		Kenneth Ric	hard Cha		1				Month Decembe		1/43 nrs		
7		4a. Facility Name (if not institut University Hospital	ion, give street and n	umber)		4b	. City, Town, or Baltimore	Location of	Death	4c. County o	: Death		
Funeral Director		5. Social Security Number 234-90-8623	6. Sex	7. Age (In y	rs. last birt		If Under 1 Year Months Day	9. Birthplace (State or Foreign VA					
Birector		Usual Residence of Decedent	1 M 2 F			Yrs.			007.12	/1956	Country) V A		
w any		10a. State 10b. County			City, Town	or Location	1		Unk 1 Yes 2 No				
ryland	Director	10e, Street and Number	Unk		_		10f. Zip Code	_		10g. Citizen of Wh			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.				Unk					Unk		USA		
ath with litems 2:	Funeral	11. Marital Status 1 Never Married 2 I	Married Armed F						? (Specify Yes or N Puerto Rican, etc.)	0- 14. Race White	- American Indian, Black, , etc.		
after de al", or i	by Fu		1 Yes ivorced If Yes, Give Ye or Dates:			1_ Y	es 2 X No	specify:		Specify:	White		
hours "natur		 Decedent's Education (Sp Elementary/Secondary (0-12 		ide completed	d) 16a.		Usual Occupa t of working life		nd of work done se retired)	16b. Kind of Bus	iness/Industry		
036 rithin 72 sne.	Completed	11		, , , , , ,					Unk		Unk		
1215-0036 de filed within 72 hours al fental Hygiene. arked other than "natural veent, the Medical Examin	Be Co	17. Father's Name (First, Middl George Earn	. ,	18.Mother's	Name (First, Middle, Helen M	Maiden Surname) lae Rams	sbura						
212 ould be d Ments s mark	일	19a. Informant's Name/Relation	ship (Type, Print)				,		er or Rural Route Nu	mber, City or Towr	n, State, Zip Code)		
, MD and 2 sho ealth and em 27 is		Heather Roz 20a. Method of Disposition	ek Da	ughte			est Mo		Ave Mart		y WV 25404 City or Town, State		
nore ages 1 ant of H.		1 Burial 2 Crematic		rom State	cremat	ory or othe			12/14/11	Glen	Burnie MD		
Baltimore, permit. Pages I an Department of Hea Important: If iter		4 Donation 5 Other 3				22. Na	me and Address	s of Facility	Simplici	ty Crem	a & Fun Serv		
Physician		23a. Part I. Enter the disease, of	or complications that	caused the de	eath. Do no								
Medical Examiner	15	failure. List only one caus Immediate Cause (Final diseas		le Inj	uries						Between Onset and Death		
<u> </u>		or condition resulting in death)	Due to (or as b.	a consequen	ce of):								
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	Due to (or as	a consequen	ce of):								
cecuted and transit	dical Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):								
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68760, certificate bo nding physic	In/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?		outcome of p	oregnancy 2	Feta	death 3	Ectopic p	regnancy	23d. Date of o	delivery Day Year		
atte atte	Physician/Me		4 Preg	nant at time o	4 -141-	=	r (Specify)						
P.O. B ss that the de gned by the		Part II. Other significant cond			not resulting	g in the und	derlying cause of	given in Part			oute to the cause of death?		
rds, P.C requires that been signed b	ted by								1 Ye		Probably 4 Unknown /ere autopsy findings available		
of Vital Records, g. Physician: The law require the this certificate has been simeral director, page 2 should b	Completed								auto	psy pr prmed? de	nor to completion of cause of eath?		
tal Rection: The certificate ector, page	Be Co	25. Was case referred to medic					26.Place	of Death (C	heck only one)	2 NO 1	Yes 2 No		
Vital F hysician: r this certifi	.0	examiner? 1 Yes 2 No		Inpatient 2		utpatient			Nursing Home 5		Other:		
on of ading Pl	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?									how injury occurre fell fr	om window		
Division tal or Attendir us after death.	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Lo									Street and Numbe	r or Rural Route Number, City		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the													
To the E within 24 To the F complete	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	ž	29b Signature and title of certif	ier (1)				29c. Licens O.C.			29d. Date signe December 4	d (Month, Day, Year)		
d		30. Name and address of person	n who completed cau	ise of death (Item 23a)						·		
W			Assistant Medica			W. Balt	imore Stree	t, Baltimo	ore, MD 21223				
St Regist	ate rar	31. Date filed (Month, Day, Year NEC 19 2011	Berna 32. K	egistrar's Sig	Bark	1							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25tate of Maryland Department of Health and Mental Hygiene for State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ Year 44 PM 201 oote Medical Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death 70 Biltimore Universit 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, If Unde **Funeral** Davs Hours Min. 215 11 6188 **Director** 1 □**X**/1 2 □ F 40 April 10, 1971 Washington DC Yrs. Usual Residence of Decedent show 10b. County 10a. State 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location Director -28a-f 1 ☐ Yes 2XX No Charles Bryons Road Maryland 1 4 1 ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral with 6568 Cornell Road United States items ; Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ö 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give XX Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: "natural", 3 Widowed 4 Divorced Completed White of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HAVAC & PLUMBING Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard H. Douglas Mary E. Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra Nichole L. Douglas (Wife) 6568 Cornell Road, Bryons Road. MD 20616 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other placel 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery 12/19/2011 Suitland MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signat re f Funer IS y e Lice Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) rannati Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury PROVED BY MEDI Due to (or as a consequence oi) Exami Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran REATIFICATIO that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ナディス Division of Vital Records, P.O. Bax 68760 attendi use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 0 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a 1 ☐ Yes 2 L 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has burector, page 2 s 24a Was an performed? 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Pay, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 \square Pending work? 1 🗌 Yes from Fall 2 Accident
3 Suicide 2. No 2011 5:45 PM after death Director: A d in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Dir

completely filled in Bryans RJ, MD 20616 89 llsmo Hows Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Within 2 3 [only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit 29d. Date signed (Month, Day, Year) 1165 1101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greens

State

Registrar

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DEC 1 9 2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dorbert sephine 16 204 /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4¢. Examiner Baltimore NURSING HOME FSS CY If Under 1 Year If Under 24 Hrs. eRVIEW Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Min. 1 □ M 2 🐺 F Months Days Hours Director IARY LANG 06-11-1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits show 10a, State 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, "19 "hodic" [Evarainer must be notlined at Director 1 ☐Yes 2 No 1 LARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code EASTERN Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it amy injury or other traumatic event. 1 ☐ Yes 2 🐼 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be O CCO Angelo ANNA UNKNEWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🔏 🏸 🗗 19a. I wrmant's Name/Relationship (Type. Print) 709 Middle Kiver Dorbert 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Addres of Facility
W. DALAROWSKITCHOSNACKI FUNERAL Homes P. A
1005 Dundalk Ave. Baltimore Maryland DIJJA 21. Signature of Funeral Service License MARYLAND 21114 23a. Part 1. Enter the disease, or complication shock or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Arterischete Cornus Verschar Immediate Cause (Final Harteman "hysician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) sician and burial-trans Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Coretrovencelas decidant 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Devienta 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?

1 Yes 2 No Hontry on's Dobace funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records,

Maryland 21215-0036

Baltimore,

attending pl this After t n 24 hours after death.

e Funeral Director: Af oletely filled in by the fur completely within 2. 0

physician

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Registrar

31. Date filed (Month, Day, Year)

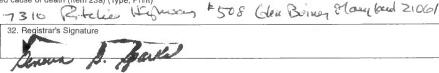
(Musserus)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Mulare

Thiseast Cu



ORIGINAL

29c. License number

D1966

29d. Date signed (Month, Day, Year)

12-17-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Day Physician December Sty, 2011 1911 Catherine Docherty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Butmare Haspital altimar Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Nov 12, 1 5. Social Security Number **Funeral** Days Months 1 □ M 2 🛱 F Maryland 52 1959 Director 218-82-9439 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shov r than "natural", or items 23a or 28a-f shov the Medical Exprogramst be notified at 1. Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21207 USA 6815 Alter Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 □Yes 2 🕅 No Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) dishwasher food industry is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Thomas Docherty ဂ္ Lillian Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 563 Kinston Road Middle River, MD Diane Barnes/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other (Specify) in state 21. Si nature of meral Service I rensee Ronal I 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sersis 4 hr /Medical Due to (or as a consequence of): Examiner Schemic Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Adhesions attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ nkrow 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s autopsy performe 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Opelator Room 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X.Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 No after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

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DHMH 17 Rev 1/2001

Docherty

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

32. Registrar Signat

RFJ-001

December

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 9, ab, 19 per inf 9924 2-2-12 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Adeline G. Domenici 2011 2:15 AM M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Nursing Home Williamsport Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex '. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F Sept 2, Year) 925 Mary Land 86 PA. Director 188-20-6539 Usual Residence of Decedent 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 Tes 2 No MD Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 154 N. Artizan Street 21795 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian. Armed Forces Black, White, etc. Yes 2 XNo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: white 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 <u>teacher</u> education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Domeniei Gannarelli Maria Gannarelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kefauver/daughter 17529 Lexington Avenue Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) le of Funera 2 VI e ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street rector MD Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate interval Between and Death Immediate Cause (Final Malianent C Physician/ Arthy thonia MINUTES disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and-tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes မှ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie December 7. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

IED HOWE MD

Year

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31. Date filed (Month, Day,

MD

WILLI AMSPORT

154 N. ARTIZAN ST.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla	-			1ental Hy	giene	ŧ 1	10110
			Registrar 1. Decedent's Name (First, Middle, La	ast) f	Ce	rtificate of D	eath	2. Date of De	Reg. No. /		3. Time of Death
	Physicia Medic		Cassardr	a YveH	e !	Earle		Dec Month	Day Y	rear	6:28PM
	Examir	ner	4a. Facility Name (if not institution, giv GriChrist H	tospile			umbia	<u> </u>	4c. County of	: 1/10	rd
4.	Funeral Director			Sex 7. Âge (In yr	rs. last birthday) 56 ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birthpl Counti	lace (State or Foreign ry) AL
	faryland 8a-f show tified at	Director	10a. State 10b. County	_^	City, Town or Lo	umbea			,	10	0d. Inside City Limits
	with the Ns 23a or 2	Funeral Di	10e. Street and Number	reart L	N	10f. Zip Code	045		10g. Citizen of Wh	at Count	try?
036	rs after death ıral", or item: Examiner m	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of His If Yes, specify Cuban, 1 Yes 2 No	, Mexican, Puerto F	cify Yes or No- Rican, etc.)		America White, e	
21215-0036	1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mental Hygiene. If Health and Mental Hygiene. And T is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		(Give	edent's Usual Occupat kind of work done du DO NOT use retired)		ng SOV	16b. Kind of Busi	ness/Ind	ealerslip
and	d be filed Vental Hyv arked oth	To Be	17. Father's Name (First, Middle, Last)	lays			18. Mother's Name	(First, Middle,	Maiden Surname)	2	V
	and 2 should Health and Mi tem 27 is mar ither traumati		19a. Informant's Name/Relationship (Type Print) Adams	19b. Maili 240	ing Address (Street and	d Number or Rural	Route Number	er, City or Town, Stat	e, Zip Co U i l	ode) 21244
Baltimore,	of it		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	o. Place of Dispo cemetery, cre	osition (Name of matory or other place)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Date 20/2011	20c. Location - C	ity or Tov	wn, State
Balt	permit. Pag Department Important: any injury o		21. Signature of Furtheral Service Licen	Bul		2. Name and Address 3220 Gu	of Facility 10	well Rd	FUNEL		D 20194
	hysician/		23a. Part 1. Enter the disease, or cor shock, or hear billure. List only Immediate Cause (Final disease or condition	one cause on each line.		ter the mode of dying,	_	r respiratory ar	rest,		Approximate Interval Between Onset and Death & BRU ARY 2011
	Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a cons							
9.	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a consi							
9	ire be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					\perp	
. Box 687	The law requires that the death certificat rate has been signed by the attending ph page 2 should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of prec 1 Live Birth 2 F 4 Pregnant at time of precent and precent at time of precent at time of precent at time of precent at time of precent and precent at time of precent at time at time of precent at time of prece	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Month		ry Day Year
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Division of Vital Records,	ine iaw ate has page 2	Completed	05 W						psy prio prmed? dea	ere autopor for to come ath?	sy findings available npletion of cause of 2 No
Vita	ysiciai s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	☐ FR/Outpatie	Other	e of Death (Check		dence 6 🕅 Other ((Specify)	HOSPICE
on of	numg Fn ath. : After thi e funeral		27. Manner of Death 1	28a. Date of injury (Month, Day, Year)	28b. Time o	f 28c. Injury a work?			now injury occurred	Орссиу	morrec
Division	al or Atter s after deg il Director ed in by th	Certificate:	3 Suicide 6 Could not 4 Homicide determined	De 28e Place of Injuny - At		reet, factory, office	2	28f. Location (\$ City or Tov	Street and Number ovn, State)	or Rural I	Route Number,
- ::	unt no spiral or Attention or Institution and the Tonara after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medica	(Check 2 Medical Exan	vsician: To the best of my knowniner: On the basis of examinates Practitioner: To the best of	tion and/or inves	stigation, in my opinion,	death occurred at	the time, date a	and place, and due to	the caus	se(s) and manner stated.
	With Co t		29b. Signature and title of certifier	OM		29c. License r	1395		29d. Date signed (I		
	//		30. Name and address of person who	ERMAN, MA	em 23a) (Type, 1	Print) CESAR		coun	noit, us	21	044
A I	Stat Registra		31. Date filed (Month, Day, Year)	32 legistrar's Sig	A. As	ale					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ďħ 2011 A^{M} January 1117 Roy Thomas Goodyear Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 248 Sycamore Road Ceci1 E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. June 15, 1 🗓 M 2 🗆 F Director Maryland 87 219-18-7111 Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 248 Sycamore Road 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married timore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 - Widowed 4 X Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Goodyear Ethel Hilman other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jane Davisson/Companion 248 Sycamore Road, Elkton, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) January 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 13, 2011 West Chester, PA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signal re of Funeral Service Licenses Bai 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ neumer disease or condition Medical resulting in death) Due to Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a cond quence of) Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy perform death? 2 🗌 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes Other: ည 2 [1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 🗌 No filled in by the Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 011 30. Name and address of person who completed

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 11:30PM Catherine Rita Gryglewski 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bal esedale timore 8. Date of Birth (Month, Day, Year) 1935 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number () 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Maryland 1 □ M 2 🗓 F Director 215-32-9714 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "social Examiner must be notified at 1 ☐ Yes 2 A No **Funeral Director** MD Harford Bel Air the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21015 United States 401 Tall Sycamore Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2XX No Specify: þ White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Krolikowski Frederick Wisniewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21015 401 Tall Sycamore Court Bel Air, Maryland Mr. Stephen Gryglewski (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Durial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. 12/17/2011 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, MD Dundalk, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on part line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the certain Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): aftending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month Year signed by the aid be detached f Ö 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 4 🗹 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No this certificate has autopsy page performed 1 ☐ Yes 2 ☑ No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica mpletely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 🖬 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification Division 5 Pending investigation 1 V Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number 72364 D72364 12/13/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

7ryglewski

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 40445 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Katharine May Harig 11:05 December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien- Taneytown Taneytown Carrol1 . Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month Day, Months Days Hours Min. 215-05-6109 ^{Year} 1918 Director 93 May Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Carroll Finksburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral 23a 1815 Fawn Wav 21048 USA death \ or items 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 Married Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give "natural". Specify: white Completed 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 7 th and Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ James Morsberger Catherine Simonds other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Thomas Harig (son) 1815 Fawn Way, Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot Page 1 1 X Burial 2 Cremation 3 Removal from State Lake View Memorial 4 Donation 5 Other (Specify) 12-17-11 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Dage Haight Herbert Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to influentate cause. Enter Underlying Cause (Disease or iinjury Examin that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ğ Month Day Year Pregnant at time of death Other (specify) ed by the a 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown s been signated the 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d, Date signed (Menth, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

ORIGINAL

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #Z per INF 6923 1/05/2011 JH State of Maryland Department of Health and Mental Hygiene 2 1 - For State Registrar 40446 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 7:57 PM M November Thamrong Hansupichon Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 12300 Downer Drive Silver Spring 5. Social Secu**313** Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-44-4622 1 X M 2 □ F **Director** Aug 27, 1946 65 Thailand Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Silver Spring MD Montgomery 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20906 12300 Downer Drive Thailand permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Deces: Armed Forces? Ves 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk merchant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Han Himphong Han Tiewtee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nong Hansupichon/spouse 12300 Downer Drive Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) nal d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Joseph and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal dea
Pregnant at time of death 3 Ectopic pregnancy5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached 1 ☐ Yes 2 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c} \text{Residence} & 6 \sup \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined

State Registrar

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Medical

29a. Certifier

(Check only one)

nature and title of certif

Date filed (Month, Day, Year)

19

mo ome

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav JONES SAM CLARENCE Dec. 2011 10:00a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday, Director 240-32-8671 1 🕱 M 2 🗆 F 83 June 6, 1928 NC oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11928 Lyons Glen Court 20754 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, à 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☒ Yes 2 ☐ No If Yes, Give 1946 — Year or Dates. 1966 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced Completed **Black** Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 | th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Chef US Army 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Estelle Foster Sam C. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Martha Edge Jones - Wife 11928 Lyons Glen Court Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-5-2012 Arlington, VA Arlington National 22 Name and Address of Facility Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 21. Signature of Far eral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death weeks Ph_ician disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner weeks Acute Cholecystitis Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Po Day Month Year Precnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, End Stage Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 1 Yes 2 No 1 Yes 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending Accident
Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) ひと 12/8/2011 D32332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, MD 20902 Suresh K. Gupta, 9801 Georgia Ave #220 MD31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TAMES HAROLD **JEFFERIES** DECEMBER 00:10 a M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton . Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Days Hours **Director** 244-68-7349 1 🕱 M 2 🗆 F 65 June 22, 1946 NC Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Prince Georges Upper Marlboro 10e. Street and Number 10q. Citizen of What Country? Funeral 9101 Fairhaven Ave. 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner 14. Race - American Indian. Black. White, etc. 1 Never Married 2 X Married è Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🖾 No Specify: "natural", Completed 3 Divorced 4 Divorced **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Dept of Interior Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ellis Jefferies other traumatic Anna Mae Phipps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Linda Jefferies - Wife 9101 Fairhaven Ave. Upper Marlboro, MD 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oak Grove Church Cem. 12-20-2011 Littleton, NC . Signature of Funeral Service Licenses 22. Name and Address of Facility
Marshall—March Funeral Home of Maryland
4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death .Physician/ 167 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to lor as a consuction of To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for נואף איזייא Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QXIV

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,11,17,18&19a&b Per ANA BD G923 1/18/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar 41449 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}, December 2011 4:05 PM M Edward Jaskulski Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Riverview Health & Rehab Baltimore Essex 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk **Funeral** Days Hours Maryland 213-40-2094 **Director** 1 □XM 2 □ F 68 Feb 14, 1943 Usual Residence of Decede or 28a-f show notified at 10a. State the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Inportrant: If item 27 is marked other than "natural", or items 23a any rijuy or other traumatic event, the Medical Examiner must b. 18 Warren Road 21221 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 2 Edward Walter Jaskulski June Berdynski 19a. Informant's Name/Relationship *(Type, Print)* **Patricia Compton—sister** 19b2W3WngAddress (Street and Number 2022. Baltimore, City of Jown, 2112314 Code) Eastern Blvd Essex, MD Riverview Health & Rehab 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 NOther (Specify) in state ure of al Service / cen onal ී එක්ස ^{and} Addres හි සිදුම්ම Board 655 W. Baltimore Street Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition andino Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death n signed by the a detached 1 ☐ Yes ∠ L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cel 1 XYes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 2 2 1 Tes completely filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 X No ျှ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709 32. Registrar's Sig State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 3. Time of Death 11:03 A M 2. Date of Death Mary Louise Kendall Physician/ Month 2/16/2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 1 □ M 2 🖾 F | 68 D5/02/1943 PA or 28a-f show 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location
Nottingham 10d. Inside City Limits Director Md Baltimore 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3922 Millner Rd. 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 X No
If Yes, Give
Year or Dates. þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Tissue Bank International Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Audrey Riesner F. Charles Baker 19a. Informant's Name/Relationship (Type, Print)
Claude G. Kendall-Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3922 Millner Rd. Nottingham, MD 21236 Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Du Pantery crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/20/2011 Timonium, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Eel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mesentenic Physician/ ischemia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Thromboembolic disease Sequentially list conditions. if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE Jse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by acherosderotic Vascular disease 1 Yes 2 No 3 Probably 4 Onknown Aortobifem bypass 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat

To the Funeral Director:
completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Practitioner: To the bost of my knowledge 29b. Signature and tile of certifier 29d. Date signed (Month, Day, Year) D 63420 December 16,2011 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 500 URPER Chesapeake Dr Chesapeake Dr Bel Air, MD 21014 31. Date filed (Month, Day, Year) Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day Year **Physician** December 1, Zelma Koontz 2011 1:30 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Glade Valley Nursing & Rehab Walkersville Frederick If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F Yrs. 220-16-0832 Director 94 Feb 11, 1917 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1☐Yes 2√2No Director MD Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 56 W. Frederick Street Funeral 21793 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Be Completed by white 3 ₩ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 healthcare nursing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dennie Belle Scheller Jesse Samuel Forney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7413 Round Hill Road Frederick, MD 21702 Norma Boone/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Drirector 21201 Baltimore, MD Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ed by the attending physicien end datached for use es the burial-transit To the Hospital or Attending Physician: The law requires that tha death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to 6 as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? eta has been signed by page 2 should be datacl 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No r: After this cartifice is funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: edicai Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural within 24 hours aftar death.

To the Funeral Director: Al
completely fillad in by tha fu I Director: Af 1 TYes 2 TNo 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26516 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICH 1445 Taney GISON MD

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

3. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Ci-i-	artment of Health and Menta tificate of Death	al Hygiene
Physician/ Medical	Decedent's Name (First, Middle, Last) Susanne Clark Ly		ate of Death onth Day Year 3. Time of Death
Examiner	4a. Facility Name (if not institution, give street and number) 19407 Gristmill Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Knoxville If Under 1 Year If Under 24 Hrs. 8, Da	4c. County of Death Washington te of Birth 9. Birthplace (State or Foreign
Director	215-62-5731 1 □ M 2 🔀 F 58 Yrs. Usual Residence of Decedent	Months Days Hours Min. 033	onth Day, Year) /15/1953 Washington DC
or 28a-f sho or outified at	10a. State 10b. County 10c. City, Town or Loc MD Washington	Knoxville	10d. Inside City Limits
leath with the items 23a or er must be r	19407 Gristmill Lane	10f. Zip Code 21758	10g. Citizen of What Country? USA
, r.a	1 Never Married 2 Married 1 Yes 2 No	/as Decedent of Hispanic Origin? (Specify Yes Yes, specify Cuban, Mexican, Puerto Rican,	s or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036 sernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam Proce. To Be Completed by	1201	ent's Usual Occupation ind of work done during most of working ONOT use retired) OUNT Executive/CSR	16b. Kind of Business Industry Private
Maryland Should be filed vand Mental Hyg 7 is marked other raumatic event,	17. Father's Name (First, Middle, Last) George Herbert Lytle		Middle, Maiden Surname) uise Schwartzinger
re, Maryla t and 2 should be if Health and Menitem 27 is marke other traumatic	Mary Louise Lytle (Sister) 9804	g Address (Street and Number or Rural Route Sunset Drive, Rocky:	
Baltimore permit. Page 1 a Department of H Important: If ite any injury or ott	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	atory or other place)	20c. Location - City or Town, State Hanover, MD
Balt permit. Depart Import any inj once.			re Funeral Services, PA eet, Baltimore, MD 21224
Physician/ Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Cance: Due to (or as a consequence of):	the mode of dying, such as cardiac or respiror of Unknown Primary	Interval Between Onset and Death
Examiner 5	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):		
60 % tebe executed hysician and he burial-transit dical Examiner	cause. Enter Underlying Cause (Disease or linique) that initiated events resulting in death) Last C. Due to (or as a consequence of):		
certificate by nding physic use as the b	d		
Attending Physician: The law requires that the death certificate be executed er death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit ertificate: To Be Completed by Physician/Medical Exami	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
dS, P.O. quires that the en signed by tould be detact	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I. 23	se. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 🛣 Unknown
DIVISION Of VITAI RECORDS, P.O. BOX To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the after completed filled in by the funeral director, page 2 should be detached for the funeral Certificate: To Be Completed by Physicial	25. Was case referred to medical	1	ta. Was an autopsy performed? ☐ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
VITAI hysician nis certiff I director	examiner? 1	26. Place of Death (Check only or	ne)
oding Ph nding Ph ith. After th funeral	27. Manner of Death 1 🔀 Natural 5 🗆 Pending 2 🗋 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury		escribe how injury occurred
UNISION OF Ital or Attending Pars after death. The Director After to led in by the funeral of the funeral Certificate:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office 28f. Loc	cation (Street and Number or Rural Route Number, y or Town, State)
the Hospita thin 24 hours the Funeral mpleted fille	29a. Certifier (Check only one) 1	gation, in my opinion, death occurred at the time, ath occurred at the time, date and place, and d	e, date and place, and due to the cause(s) and manner stated. due to the cause(s) and manner as stated.
ō ō ō	29b. Signature and title of certifier Mick 1 acrocl	29c. License number 67258	29d. Date signed (Month, Day, Year)
8			uite 300, Rockville, MD
State Registrar	31. Date filed (Month, De.), Wear) 32. Figurer's Signature.	ald	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Larkin Thomas Livesay Jr. 2011 4:20 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3840 Watson Lane Carrol1 Union Bridge If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 € M 2 □ F Months (Month, Day, Year) arch 24 Director 214-26-2172 81 March 1930 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Carrol1 Sykesville 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 1136 Fannie Dorsey Road 21784 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married 1 V Yes 2 No Korea Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Year or Dates marked other than "nature imatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Genstar supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Larkin Thomas Livesay Sarah Ann Testerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Jenkins (daughter) 19 W. Meadow Grove, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury (12-17-11 Sykesville <u>View Memorial</u> 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Page Haight Herbe P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Examine the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? jo Day Month 5 Other (specify) Pregnant at time of death 2 No ed by the a detached f a I Ilnknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tor. After this certificate has been signed in the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined thin 24 hours at the Funeral E Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NILARU, M.D Westmenster MD 21157 Washengton 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Year} 2011 Arnold Henry Myers 29 December 6: Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 39 Cinder Road Baltimore Timonium Social Security Numbe Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min **Director** 214-20-9082
Usual Residence of Decedent 1 X M 2 🗆 F 88 11/03/1923 show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD 1 Yes 2 X No Baltimore Timonium 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be Funeral 39 Cinder Road 21093 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Year or Dates. WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: "natural" Completed 3 Widowed 4 Divorced White al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Carpet Installation Be 17. Father's Name (First, Middle, Last) of Health and Mental H If item 27 is marked ot r other traumatic even 18. Mother's Name (First, Middle, Maiden Sumame) မ Benjamin **Myers** Catherine **Holtzhaus** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is 7 or other trai 39 Cinder Road, Timonium, MD 21093 Barbara Myers, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Most Holy Redeemer 12/17/2011 Signature of Funeral Service Licenses 22. Name and Address of Facility Dephara 5305 Harford Road, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Drin to for as a nonsequence of is or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and use as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Month Year signed by the at Id be detached for 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 funeral director, 25. Was case referred to ica Be 26. Place of Death (Check only one) examiner? 101 Other: 1 Yes 2 No 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 🗌 No 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day

9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 40455 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ Day 16 2011 9.00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel H05 HOL **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Director 47732 7138 1 🗶 M 2 🗆 F MINNESOTA A46457 4.1931 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland be notified at Director 1 Yes 2 No ANNE ARUNDEL PASADENA MD 10e. Street and Number ŏ 10g. Citizen of What Country? ms 23a (must be Funeral JOHNSON STREFT 1122 4,5,A Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give MARCH 3.51 Year or Dates. MARCH 17.55 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced Specify: WHITE Completed th and Mental Hygiene.
27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) AEROSPACE 12 LECTROMICS TECK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ROSALIA R. MCDERMOND CLINTON MAHER 19a. Informant's Name/Relationship (Type, Print) wiFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 48 JOHNSON STREET MEDERMOND PASADENA MO item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ō ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) CREMATIONI DEC. 19. 2011 HANOUER, MO AROEMT 22. Name and Address of Facility MARZULLO FUNERAL CHAPEL . Signature of fur ral Service m00078 LED 6009 HARFORD ROAD BALTIMORE, MD 21214 23a. P. rt. 1. Iter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between mmedice Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month signed by the at the detached for Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe Yes 2 this certificate the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospital: 유 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After Natural 5 Pending s after death. Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical Name Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Yea.

DHMH 17 Rev 06-2011

State Registrar Setal Drive, Gula

e of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sonia Anita Midgett State of Maryland / Department of Health and Mental Hygiene 2011 40456 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Time of Death Month Month Day December 7, 2011 Medical Examiner 1806 hrs MIDGETT ANTTA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince George's **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Davs Hours 2 X F Country) 1 M Yrs 52 10-07-1959 DC 480-84-1657 Usual Residence of Deceden 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Prince Georges Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f she Greenbelt Director 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8659 Greenbelt Rd. #101 20770 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Never Married 2 Married 1 Yes 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Black. Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. the Medical 4 yrs. Accounts Payable Clerk Public Health Assoc. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Dell Fennell Vera Haves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Young - Sister 8659 Greenbelt Rd. #101 Greenbelt, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State nt of H crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify. 12-16-2011 Washington National Suitland, MD 21, Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line 8etween Onset and /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate iner Due to (or as a consequence of): Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED ate of delivery Year Day contribute to the cause of death?

The law requires that the death certificate be executed ned by the attending physician detached for use as the burial -Division of Vital Records, P.O. Box 68760, this

After To the mospher within 24 hours after death.

To the Funeral Director: A

	IF FEMALE:	20. 11							
		23c. If yes, outcome of pregn	iancy				23d. Date of d	lelivery	
2	23b. Was decedent pregnant in the	1 Live birth	- Fatal de att	3	Ectopic pregna	no.	Month	Day	Year
3	past 12 months?		2 Fetal death	1 3		iricy	MOHUI	Day	rear
5		4 Pregnant at time of dea	ath 5 Other (Spe	noifu)		1.0			
5	1 Yes 2 No 9 V Unknown		Uther (Spe	-					
•	100 2 110 9 \ Officionni	9 Unknown							
•	Dark II Other II 15 and 1811	L						_	
-	Part II. Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause g	iven in Part I.	23e. Did toba	cco use contrib	ute to the cau	use of death?
•	600							7	
•						1 Yes	2 ✔ No 3	Probably 4	4 Unknown
3									
•						24a, Was an	24h W	ere autopsy fi	indings available
•						autopsy			ion of cause of
-						performe		eath?	ion or cause or
6						1 Yes 2	_ No 1	✓ Yes	2 No
,	25. Was case referred to medical			26.Place	of Death (Check	only one)			
)	examiner?	spital:			Other:				
,	1 ✓ Yes 2 No	Inpatient 2	ER/Outpatient 3	DOA	Other Nursin	g Home 5 Re	sidence 6	Other:	
	27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c Injur	ry at Work?	28d. Describe how	iniuo, occurre	d	
	1 Natural 5 D	(Month, Day, Year)	,_,		,	200. 0000/120 /101	injuly cocamo	-	
2	1 V Natural 5 Pending			1 Y	res 2 No				
	2 Accident Investigation	.							
1	2 Accident investigation		me form atract factor	65 b	ultalian ata	001 1	- 1 1 h 1 h	D 15	
	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, tarrii, street, tactor	y, office bi	ullaing, etc.	28f. Location (Street or Town, State		or Rural Rou	ite Number, City
	determined	(Specify)			ŀ	or rown, state	=)		
	4 Homicide	1-6							
1	29a. Certifier 1 Cortifidas Physician	To the best of my knowledge	a death againmed at th	- 61		d	\ d		
П	(Check only Certifying Physician	n: To the best of my knowledge	e, death occurred at th	e time, da	ite and piace, and	que to the cause(s	i) and manner a	is stated.	

30. Name/and address of person who completed cause of death (item 23a) Pamela E. Southall, MD Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year) State Registra

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

December 8, 2011

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40457

_			For State Registrar		State of I	viaryian	•	artment <i>tificate</i>			and IV		giene Reg. N			40407
	Physicia		1. Decedent's Name	e (First, Middle, La: PALN	,	MOORE						2. Date of De Month	D.	12 2	Year	3. Time of Death
	Medic Examir		4a. Facility Name (if	not institution, give	street and number		. 1	4b: City, To	n / \		. //.	L		c. County	of Death	19 10 20
	Funeral		Maryla 5. Social Security No.		reral H)Spito Age (In yrs. Ia	ast birthday)	1 Swinder 1	Year	MOCC If Under	24 Hrs.	8. Date of Birt				lace (State or Foreign
	Director		244-44-2 Usual Residence		□ M 2 🕱 F	80	Yrs.				Min.	(Month, Da. Jan. 2		**		**
	/land f show d at	ţoţ	10a. State	10b. County		10c. City	, Town or Lo	cation							10	Od. Inside City Limits
	ne Mary or 28a- notifie	Direc	MD 10e, Street and Nun	Prince G	Georges	Ade	1phi	10f. Zip C	ode.				10- 0	itizen of W	/hat Carre	1 Yes 2 No
	s 23a o	Funeral Director	10505 E	dgemont D	r.				0783	3			_	USA	viiai Oouii	uy:
(0	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Inportant: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Fui	11. Marital Status 1 Never Marri	ied 2 🗌 Married	12. Was Deceden Armed Forces 1 \(\subseteq \text{Yes} \) 2 E	?	i. 13. V	Vas Deceder Yes, specify	nt of His / Cuban	panic Orig , Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)			e - America k, White, e	
9 6	ours aft tural", al Exar	Completed by	3 🗌 Widowed		If Yes, Give Year or Dates.			☐ Yes 2						Specify:	Blac	ck
00RE	in 72 hc e. han "na Medic	mple	(Spe	15. Decedent's E cify only highest groundary (0-12)		r 5+)	(Give A	ent's Usual (and of work of NOT use re	done du	tion <i>ıring m</i> ost	of workin	ng .	16b.	Kind of Bu	siness/Ind	lustry
2	ed withi Hygiene other th	Be Co	17. Father's Name (2 yrs	. 01)	Cust	odian		40.14.10.		Office and the state of the sta		Univ		ty
Annie moore Baltimore. Maryland 21215-0036	d be file Mental arked c	10	Henry Pa	. ,	N.				- 1			(First, Middle, Reeves		i Surname))	
Annie Jue Marvie	2 shoul th and I 27 is ma trauma		19a. Informant's Na				1					Route Numbe				ode)
And Property	of Heal of Heal fitem		Edna Thor	position			7330 lace of Dispos emetery, crem	Green	of	T		Lanham,		_ocation -		wn, State
time /	it. Page rtment rtant: I rjury o		4 Donation	5 Other (Special			surrec	tion (Ceme	tery		21-2011				
Ba	permi Depar Impol any ir		21. Signature of Tur	Reno (Wood	1	Ma 43	rshal 08 Su	Address l-Ma itla	rch nd R	Fune:	ral Hom Suitla	ne o	f Mar MD 2	ylan 20746	d
	Physician/ Medical Examiner	ner	shock, or hear Immediate Cause (I disease or condition resulting In death) Sequentially list con	t failure. List only o Final n nditions,	b. ASPIR	ed the death ine. OS/S s a conseque	ence of):	r the mode o		p-	cardiac or				LU	Approximate Interval Between Onset and Death NKWWYY
8760		Medical Examiner	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	injury	C. Due to (or a	s a consequ	ence of):									
O, Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/N	23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	norths?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	n 2 🗍 Fetal at time of de	death 3 = eath 5 =	Other (spec	cify)					23d. Date Mon	e of delive	ry Day Year
'ds, P.O,	requires that been signed should be de	by	Part II. Other signifi	icant conditions of	ontributing to death	but not resu	ulting in the ur	nderlying cau	use give	n in Part I.				/		e cause of death? ably 4 \square Unknown
Division of Vital Records,	ding Physician: The law re h. After this certificate has b funeral director, page 2 sf	Completed												pr de	/ere autoporior to conteath?	sy findings available apletion of cause of 2 No
Vita	is certif	To Be	25. Was case referre examiner? 1 Yes 2	+	Hospital:	atient 2 🗆 E	ER/Outpatient		Other	e of Deat		only one) ne 5 🗆 Resid	lence (6 ☐ Other	r (Specify)	
ion of	Attending Phr r death. ctor: After th by the funeral	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide	5 Pending Investigation	28a. Date of in (Month, D	jury	28b. Time of injury		. Injury a work?	at	2	8d. Describe h				
Divisi	To the Hospital or Attend within 24 hours after death To the Funeral Director; / completely filled in by the t	al Certi	4 Homicide	6 Could not be determined	28e. Place of Ir building, e	etc. (Specify)						City or Tow	n, State	9)		Route Number,
	To the Hospital within 24 hours on the Funeral I completely filled	Medical	(Check 2 only one) 3		sician: To the best of ner: On the basis of se Practitioner: To t	examination	and/or investi	gation, in my death occurre	opinion ed at the	, death oce time, date	curred at t	he time, date and e, and due to the	nd place he cause	e, and due e(s) and ma	to the caus anner as st	se(s) and manner stated. ated.
	50 00 00		29b. Signature and t	mag 5	Sharm		D		89	Le G	1		29d. Da	12//	(Month, D	ay, Year)
ے	11		30. Name and addre	na J'h	arma,	m.	D. 9	int)	are	4/01	nd	Giere	ral	2 x	Sosp	ital
	Stat Registra	-	31. Date filed (Month	FC 1 9 20	11 Sa Regist	trar's Signati	ha	Kal								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40458 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Jean Mason 8:20 p Betty Medical becamber 011 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Kandallstown altimore HOSPICE Northwest 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) **Director** 1 M 2 X F **ωω** Yrs. show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 No No House 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ems 23a or r must be r Funeral 21201 items ? within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", 3 Modowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Education eacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ vanke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Department of Health ar Important: If item 27 is any injury or other *** promo Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Surial 2 Cremation 22/2011 4 Donation 5 Other (Spe-Sur ature / Funeral Service Lice 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ canter VAGINA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-1 Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 as t IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ģ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform Yes 2 No Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 P No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural work? 1 Yes 2 No 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year) M 5 RajapakueM.D 12/15/11 DOUS7 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar s Rajapakse, M.D.

31. Date filed (Month, Day,

2835 Smith

5 203

Baltimore MO 21205

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40459 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Examiner ility Name (if not institution, give street and number) 4b. City, Town, or Location of Dear punty of Death da KesVI 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth 1 M 2 X F Min 0471271956 Director 311-54-4614 55 Yrs Indiana Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland Examiner must be notified at **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Md Carro11 Sykesville 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a 710 Obrecht Rd. 21784 USA Page 1 and 2 should be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: White and Mental Hygiene.
is marked other than "natur raumatic event, the Medical | 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Site Director Non-Profit Finance Fund[Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Meredith Nicholson Elizabeth Crist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Elizabeth C. Nicholson(Mother) 2224 A Boston Court Indianapolis, Indiana 46228. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State All County Cremation 12/16/2011 4 Donation 5 Other (Specify) Sykesville, Md. 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Fund at Service Licensee P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -tran and that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year signed by the a 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? After this certificate 2 No 1 Yes 2 No the Hospital or Attending Physician: thin 24 hours after death. Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other 2 🔀 No ျပ 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

710 Obrecht

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2011 Team Agnes Louise Naquin 16:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min (Month, Day, Year) Director 195-24-4280 82 1 □ M 2 🗶 F Yrs Oct. 27, 1929 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Prince Georges Upper Marlboro 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 9802 Luke Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Holp Elizabeth Bartos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Sellers (Daughter) 1200 Rustic Creek Dr. Centerville, OH 45458 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 27, 2011 Cheltenham, MD MD Veteran's Cemetery 21. Signeture of Funeral Service License 140122 22. Name and Address of Facility Lee Funeral Home. Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Kespivatory Earlure - AsthmA Physician/ Heute and Chronic disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami g physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last cardiovascular discuse with hypertension Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No for Month signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kyphos coliosis 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completely filled To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Upper Manlhoro. 9 son who completed cause of death (Item 23a) (Type, Print) MD Champaloup MO 6.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40461 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 4 2011 8:38 PMM December Cynthia Lee Newman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown 20304 John F. Kennedy Drive #313 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 215-34-3725 1 🗆 M 2 💢 F Mar 7, 1936 Maryland 75 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified or 28a-f 1 Yes 2 X No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral 20304 John F. Kennedy Drive #313 21742 must USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. marked other than "natural", or i matic event, the Medical Examin 1 Yes 2X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 office worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 William James Sullivan II Claudine Gladys Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .0 27 Jody Reider/son Tamarack Road Sparta, NJ item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) ein, ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signi Director Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Herahis C with Herahic Encephalope Ph_sician/ -Iver Circhosis disease or condition Medical resulting in death) Examiner Combine 1 Chronic Sustalic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events COPD and as the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year Pregnant at time of death ed by the at detached for 1 L Yes 2 L 9 L Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death?

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1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autop., performed, 2 12 N 1 🗆 Yes 2 12 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 4 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

completely filled in by the funeral director, after death. Director: After this 24 hours To the within 2

> State Registrar

Medical

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Stesano Maddoon

Jefferson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

MD

Smiths burg

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0071052

29d. Date signed (Month. Day, Year)

29c. License number

21783

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** harr 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sykesuille Brinton woods Carro 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 1 M 2□F 76 Director 234-56-6698 13 1935 Aug Usual Residence of Decedent 10c. City. Town or Location 10a. State 10h. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐XÑo MD Carrol1 Director Finksburg with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1928 Deer Park Road 21048 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ð Specify: white 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than computers computer programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Louise Moore Walter Wellington Pharr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any Injury or other tra once, Mary Ann Pharr (spouse) 1928 Deer Park Rd., Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) All County Cremation 12-14-11 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Day P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caus ... death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Deenaug uks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and I-tran physician a sthe burial-1 Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? Month 5 Other (specify) signed by the a 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Únknown 1 ☐ Yes 2 □ No been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? Yes 2 ☑ No certificate 1□ Yes Physlcian: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 □ DOA Medical Certification: To this funeral c 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of cortifie 29d. Date signed (Month, Day, Year) 10806 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 10 Rus as

BUSINOSS

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# 30 per DVR, G922, 12/19/2011, WS
State of Maryland / Department of Health and Mental Hygiene

State amend item 7 per fh g922 12-28—11/19/24te of Death

Reg. No. 201 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month De c 612 A M Peterior Irvind VONAR 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 6 Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Months Director 66 1 M 2 X F CARTLIWA ms 23a or 28a-f show must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 154 items be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 nd Mental Hygier marked other t Be 17. Father's Name (First, Middle, Last, မ Department of Health and Ment. Important: If item 27 is marked any injury or other. 19a. Informant's Name/Relationship (Type, Prigt) D (ChTER 19b. Mailing Address (Street and Number 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licer Me 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition DUMONASY edeno Medical resulting in death) Due to (or as a consequent of): Examiner Malianant Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events District to (or as a donsequence of) law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) physician a the burial Physician/Medical Records, P.O. Box 68760 as attending IF FEMALE asn 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ģ Month Pregnant at time of death Day Year the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 YNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy perform To the Hospital or Attending Physician: The certificate Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 🗹 No Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. N. Kawa 00066515 2011 Doc 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard County General Hospital Columbia, MD 31. Date filed (Month Day, Year)

DHMH 17 Rev 06-2011

State Registrar

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Ellen Marie Paszula 822 AM 16 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square Hospital Rosedale BalTimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. 6. Sex 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours 04-0901948 New Jersey Min. Director 146-40-0160 63 Usual Residence of Decedent 10h County 10c. City, Town or Location show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☑ Yes 2 ☐ No Maryland N/A 28a-f Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3103 Echodale Avenue 21214 items 23a USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give permit, Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or any Injury or other traumatic event, It we Medical Example. 21215-0036 ğ 1 ☐ Yes 2 ☑ No Specify White Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Home Cleaning Service Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SZULa Albert Nastanovich Marie Koncz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kim Paszula - Daughter 3103 Echodale Avenue Baltimore, Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Hillton Service Corp. 12-18-2011 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fund I Servin 22. Name and Address of Facility 5305 Harford Road Baltimore, Maryland 21214 Leonard J. Ruck. Inc. 23a. Part 1. Enter y e disease, or coo li ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he it failure. List or yo e cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in death) **Physician** m etastaTic OVacian cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) the defached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CA.D tension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 DR noshin Qaisrani 9000 FRANKLIN Square DR Balto md 21237

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40465 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 201 Mary Agnes Ryan Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** LAPLATA HAR If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 219 56 0399 1 🗆 M 2 💥 65 Sept 14, 1946 Washington DC Usual Residence of Deceder show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 10200 LaPlata Road 20646 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, 1 XXNever Married 2 - Married Yes _2**XX**No 1 Yes 2 No If Yes, Give Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) N/A Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nelson Leon Ryan Anna Pauline Oertly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7700 Kippling Parkway, Forestville, Louise Oertly (Cousin) MD 20747 20a. Method of Disposition
1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Lee Crematory Dec 17, 2011 Clinton, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Ph_sician/ Diverticu disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate beneal once after death.

Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Other (specify) Pregnant at time of death 1 ☐ Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 1 / Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 within 2 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HarrING

DHMH 17 Rev 06-2011

State Registrar 32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Karen Lee Mattes Reger 3:13p December 20T1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Westminster 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1th 29^{y, Year)}967 Min Days 1 🗆 M 2 💢 F 44 219-98-6005 Nov Director Usual Residence of Decedent show 10d. Inside City Limits of Health and Mental Hygiene. item 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Carrol1 Westminster 1 ☐ Yes 2 X No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21157 31 Washington Lane Apt. E death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify white Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) food service cafeteria manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nancy Trageser Edward Mattes Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2428 Forest Hill Rd., Marriottsville, MD 21104 19a. Informant's Name/Relationship (Type, Print) Nancy Mattes (mother) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, - i - i 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Department of Important: If any injury or All County Cremation 12-22-11 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee Pagi Harght Herber Box 195 Sykesville, MD 21784 P.0. 23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one ca ath. Do not enter the mode of dying, such as carpias or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical u to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Vear Pregnant at time of death ate has been signed by the page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 -No 1 🗌 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 1 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signat

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

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ernard Hicks Robinson, Jr.	State of Maryland / Department of Health and Mental Hygiene		0011	1010
1- For State	Certificate of Death	Reg No	2011	4040

		Registrar Certificate of Death Reg. No.												
Physicia ledical Exami		Decedent's Name (First, Midd	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year December 5, 2011											3. Time of Death 2000 hrs
		4a. Facility Name (if not institution 5957 Fisher Road #10	on, give street and nu				City, Town, or Lo Temple Hills	ocation of	Death			ounty of	f Death eorge'	's
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I		1	If Under 1 Year Months Days	If Under Hours	Min		,	1	Foreign	
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any		Usual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Loc	ation	1							10d. Inside City Limits
▶	0		e Georges	Te	mple H	il	.1s							1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatie event, the Medical Examiner must be notified at once.	Director	10e. Street end Number	1 #10/			1	10f. Zip Code			1	0g. Citizen	of Wha	at Count	try?
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215 e filec tal Hy ked o	Be C		Bernard Hicks Robinson, Sr. Edna Harris											
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MD d 2 sh lth an n 27 i		Kennedy Robins	son - Son				yman Cou			anside	,		9205	
of Hea	h.	20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal fr		Place of Disper crematory or o		on (Name of ceme r place)	etery,	D	ate	20c. Loc	ation -	City or T	Town, State
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/Medical		failure. List only one cause	on each line. Hyp	pertensi	ve Ath	er	osclerot	tic (Cardi	ovascu	ılar			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	3-0-0	consequence of		ca	Lions							
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8760, tificate be exing physiciar as the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the		outcome of preg				Testonio	pregnancy			ate of c		ay Year
Sox 687 leath certifing e attending properties of the second	ciar	past 12 months?	I TIVE D	oirth nant at time of de	oth		death 3 <u> </u>] Ectopic	pregnancy	<i>'</i>	IVIC	or itt i	D	ay real
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rision ratte	ficat		stigation 28e. Plac	e of Injury - At ho	ome, farm, str	eet,	factory, office buil	lding, etc.	. 28			Numbe	r or Rur	ral Route Number, City
Divisior Hospital or Attend 24 hours after death Fuoeral Director:	E.	3 Suicide 6 Could not be determined (Specify)												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuceral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi												d. e cause(s)		
To the within To the comple	Medical	29b. Signature and title of certifie	and manner s	tated.		,	29c. License			,				oth, Day, Year)
			1 11	7			O.C.M		OGM	E	Decen			
/		30. Name and address of person who completed cause of death (I(sh 23a)												
10		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223												
St Regist	ate rar	31. Date filed (Month, Day, Year)	2011 32. R	gistrar's Signatu	J. A	a	Kel							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edwin В. 2011 9:15 Rakowski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday If Under **Funeral** (Month, Day, Year) Days Hours Min 219-16-2831 Director 1 X M 2 🗆 F 88 Vrs 11/05/1923 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location must be notified at Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3804 Glenarm Avenue U.S.A 21206 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Operations Manager 12 Trucking other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ပ Sobieski Alvina Benjamin Rakowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Mary Jane Rakowski, Wife 3804 Glenarm Avenue. Baltimore.MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 0 Department of Important; If any injury or 12/21/2011 Gardens of Faith Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Devandria 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner CARDIOVASCULAR dequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the al 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? ဂ္ 1 \square Yes 1 Inpatient 2 Froutpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number

51

31. Date filed (Month, Day, Year)

TOSERH M.D. 5601 LOCH RAVEN BLVD BACTIMORE MD 21239

1921 1 192011 Seven S. Sand

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

D58933

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Plea		•			d / Depa		t of H	lealth		lental Hy	gien			404	69
Physicia		Registrar 1. Decedent's Name Aravill			nerts								2. Date of De Month Novembe	ath			3. Time of De 10:02	
Medic Examin		4a. Facility Name (if 8528 Fc	not institution	, give stre	et and nun						Location svil			4	-	of Death	ek	
Funeral Director		5. Social Security N 215-20-	umber 2869	6. Sex	л 2 X F	7. Age	(In yrs. la	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Aug 2,	y, Year)		9. Birthp Count Mary		oreign
Aaryland Ba-f show tified at	Funeral Director	Usual Residence of 10a. State	10b. County		ville		10c. City	Town or Lo	ocation 10d. Inside City Limits lerick 1 □ Yes 2 🛣 No									
with the Ns 23a or 23ust be no		10e. Street and Number 8528 Fortune Place							10f. Zip Code 21793					10g. C		What Coun	try?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marr 3 ሺ Widowed		ried	Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	orces? 2 💢 N ve			Was Deced f Yes, spec 1 Yes	cify Cuba	n, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)			ce - Americ ck, White, e	te. te	
within 72 houn giene. er than "natu the Medical	Completed	(Spe Elementary/Seco 12	15. Decede ecify only highe ondary (0-12)			I-4 or 5+	-)		dent's Usu kind of wo O NOT use	rk done d		st of worki	unk ing	16b.	Kind of B	Business/Ind	dustry U I	ık
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nd 2 shoul ealth and I m 27 is m ner trauma		19a. Informant's Na Elaine	Earls/c										al Route Numbe 1kersvi	.11e	, MD	217	93	
Page 1 a tment of H tant: If ite jury or oth		20a. Method of Disp 1 Derial 2 4 Donation	☐ Cremation		moval from	State		lace of Dispo emetery, crei			re)		Date	20c.	Location	- City or To	wn, State	
permit Depari Impor any in		W.	neral Service			Sire			Ba1	timoı	re, M	D	ard 655 21201		Bal	timor	e Stree	t
Physician/ Medical		23a. Part 1. Enter the shock, or heal immediate Cause (disease or condition resulting in death)	ırt failure. List : (Final	r complicationly one of	ause on e	ach line.	105	cler			7		or respiratory ar	-	Sea	se	Approximate Interval Betwe Onset and De	en ath 5
Examiner	ner	Sequentially list co	nmediate	b.		`	consequ	·							_			
be executed sician and burial-transit	al Examiner:	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):									_				-		<u> </u>	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Medic	d							Ectopic pregnancy Other (specify) 23d. Date of delivery Month Day						ar			
ires that th signed by Id be detac												3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown						
The law requate has beer page 2 shou		Congestive Heart fail							24a. Was an autopsy finding prior to completion of death? 1					mpletion of cau				
sician: certific irector,	Be	25. Was case referrexaminer?	red to medical	Hos	pital:	_				Othe	er.		k only one)					
nding Physath.	Certificate: To	27. Manner of Deat 1 Natural 2 Accident	ner of Death Natural 5 Pending Accident Investigation Suidide © Continued on the property of t				ce 6 ☐ Other (Specify) injury occurred											
ital or Atte ins after de al Directo led in by th		3 ☐ Suicide 4 ☐ Homicide	6 Could detern				y - At ho (Specify)	me, farm, sti	eet, factor	y, office			28f. Location (City or To			ber or Rura	Route Number	
the Hospi thin 24 hou the Funer mpletely fil	Medical	(Check 2 only one) 3	Medical Certifying	Examiner	On the ba	sis of ex	amination	and/or inves	stigation, in e, death occ	my opinio curred at t	on, death on the time, d	occurred a	nd due to the c t the time, date ace, and due to	and pla the cau	ce, and du ise(s) and	ue to the ca manner as	use(s) and mann stated.	er stated.
New Yes		29b. Signature and	an F	-	cres	, U		20.) 5	29d. Date signed (Month, Day, Year) D37197 December 9,2010 Print) Street inches in the signed (Month, Day, Year)					21				
0.		30. Name and addr	Toler	who com	MD.	1	ath (Item 5 // 's Signat	23a) (Type	Print)	Sti	rect	1	Fred	10	~161	EM.	D ZI	701
Stat Registra		Date filed (WOII	EC 19	2011	12	registral	3 Olyrial	ha	Med		,							

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

within 24 hours after To the Funeral Dire

Lessa Mouse CRNF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. Belvedere Ave, Baltimore MD 21215 State Registrar

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Medical

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4, December Physician/ 2011 8:25рт м Norwood Shelbaer William . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll **Examiner** Eldersburg 5904 Dale Drive 8. Date of Birth
Jan . 22, 1927 9. Birthplace (State or Foreign Country) DA 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Months 1**X**□ M 2 □ F 165-22-5458 **Director** 84 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Director 1 Yes 2 XNo **Eldersburg** Carrol1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21784 5904 Dale Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White WWII 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Trucking Mechanic 2 should be filed with h and Mental Hygier 7 is marked other t permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Durst Joseph Lamar Shelbaer (daughter) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5214 Woodbine Rd., Woodbine, MD 21797 Mrs. Verna J. Giulioni-Hill 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 12/19/2011 Lake View Mem, Park 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses PO box 195 Sykesville, MD 21784 400764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition)

Bacterial Physics American Physics Physics American Physics Physics Physics American Physics Approximate Interval Betwee Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of and -tran that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 ing physician as as the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending poshed for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ destive 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law cate has by page 2 s autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is 1 Yes 2 No Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 27 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Sertifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) and title of certifie 29c. License numbe 29b. Signatur 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w17 2 idle Road Westminsts 2115 32, Registrar's Sig State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 10:10 PM ecember 2011 Medical give street and number 4c. County of Death 4a. Facility Name (Facility Name (if not institution, 4b. City, Town, or Location of Death **Examiner** View tional 010 ike If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday, Country) Virginia **Funeral** Days Hours 0272671920 Months 1 - M 2 XF 91 218-22-3877 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ?? any injury or other traumatic event. the Maryland once. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Tes 2 No Baltimore Md Woodstock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21163 10600 Davis Ave C-15 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Force Black White etc. þ 1 Never Married 2 Married 2 No Yes 1 ☐ Yes 2 No Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewife 6vrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lena Byrns William Boyant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10600 Davis Ave C-15 Woodstock, Md. 21163. William Lee Shoemaker(Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/22/2011 Sykesville, Md Lakeview 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Haight Funeral Home & Chapel Box 195 Sykesville, Md. 21784 P.O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final STROKE Physician/ ACUTE LER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner YPERTENSION Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 M No DISEASE 3 Probably 4 Unknown CORONARY ARTERY 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? SENILE DEMENTIA. 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျု 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No Investigation ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 3

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NBVELLANKI 8850, COLUMBIA 100 PARKWAY: #308, COLUMBIA, MD. 21045

30 469

29d. Date signed (Month, Day, Year)

Descuber 19, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Charlotte Saxon 12/16/2011 5:45A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Bel Air Victorian Estates If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 220-16-0209 Months Hours Min 04/06/1925 Country) WV 86 **Director** 1 🗆 M 2 🖾 F Yrs Usual Residence of Decede show 10d. Inside City Limits 10a. State 10b. County notified at 10c. City. Town or Location Director Harford Bel Air MD 28a-f 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be r 9 Funeral 21014 144 N. Hickory Ave. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 K No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 k Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Martin Marietta Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Carrie Osborne D.S. Pennington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis M. Saxon Jr. Stepson 17121 Urban Ave. Port Charlotte, FL 33954 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State St. Michael Luth Ch 12/19/2011 Nottingham, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Schimunek Funeral Home Inc. ture f Funeral Service Licensee 9705 Belair Rd. Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ end store Designiti disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate has director, page 2 performed Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Asst Living ္ဝ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at work? iniury Natural 5 \square Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Decomberts 2:11

State

Registrar

1

32. Registrar's Signature

MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:30 Mary Elizabeth Stanton December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Min. **Director** 150-32-0307 1 □ M 2 🔀 F 03-29-1942 69 New Jersey Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Tes 2 No MD Anne Arundel Crofton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ŏ ems 23a or r must be Funeral 1620 Ebbotts Place 21114 United States er than "natural", or items the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emil Barth, Sr. <u>Mary Leah Kennedy</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George J. Stanton / Husband 1620 Ebbotts Place Crofton, Maryland 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 12-14-2011 Odenton, Maryland 21. Signature of Juneral Service Licensee Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 🗌 in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 5 Other (specify) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 After this certificate has funeral director, page 2 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes npatient 2 - ER/Outpatient 3 - DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Natural work? 1 Yes 2 No Accident Investigation 24 hours after deatle Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of cent 29d. Date signed (Month, Day, Year) 29c. License number 12-13-2011

Registrar

DHMH 17 Rev 06-2011

mnapelis

MD 21401

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's agnature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			Pleas	se Type or	Print in	Black	Indelib	le Inl	k. Ens	ure A	II Copie	s Ar	e Leg	ible.		
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		State Registrar				C	<u>Certificat</u>	e of L	Death			Reg. N	0.21		4	0475
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Medic	cal		Lee Smi								Decemb	er l	0, 2	011	4:1	5 AM M
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			5 N Other (Sp	9	tate		00.41									
permir Depar Impor any ir once.		21. Signature of Fun	eral Service Lic Conal d S	Wade,	bi/rect	or	22. Name ar State	Anat	omy	Bgarg	655 W	. Ва	altin	ore	Stree	:t
		23a. Part 1. Enter t	he disease, or co	omplications that of	aused the de	ath. Do not	enter the mod	e of dvind	a. such as	cardiac o	r respiratory ar	rrest.			Approxin	
Physician/		shack, or hear Immediate Cause (rt failure. List on	ly one cause on ea	ch line.						, ,				Interval E Onset an	Between
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eath. or: At	lfica	2 Accident 3 Suicide	Investiga	tion			M		Yes 2 🗆	No						
or Att	Certificate:	4 Homicide	determin	28e. Place	of Injury - At Ing, etc. (Speci		street, factory	, office			28f. Location (S City or Tov			er or Run	al Route Nu.	mber,
To the Hospital or Attending Physician: The law requires that the death certificate be within 2 burns after death certificate be within 2 burns after death. To the Euhoral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burns lateral times.		00- 0-46 4	Zowii in B	No atata a Tanta a I		ulada la			4							
Hos 24 hr Fun etely	Medical	(Check 2	Medical Exa	hysician: To the baminer: On the bas	is of examinati	on and/or in	vestigation, in	my opinio	n, death o	ccurred at	the time, date a	and plac	e, and due	to the c	ause(s) and	manner stated.
To the within To the Complete		29b. Signature and t		lurse Practitioner	: IO the best of	THY KHOWIEC		. License		ite and pia	ce, and due to				Day, Year)	
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•		30. Name and addre	ess of person wh	OV WING		m 23a) (Typ	e, Print)	ט טנ)6319)		<u>D</u>	ecemi	JeI .	10, 20	711
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Registra	ar	_	DEC 1 S	2011	Lucia	1.	back									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Leah J. Schramm 8:25 P Decembe: Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-Frostburg Nursing & Rehab Center Allegany Frostburg 8. Date of Birth Jan 9, 1919 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Mary land Director 217-19-1108 Usual Residence of Decedent should be filed within 72 hours and word.

I and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-f shov

I is marked other than "natural" or items be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 48 Tarn Terrance Road 21532 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) salesperson footwear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Spicer Susan Shields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Chris Tyler/granddaughter 29694 Rungneck Place Salisbury, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) Signature of Foneral Service Licensee ROTTa La State Anatomy Board 655 W. Baltimore Street my Baltimore, MD 21201 23a. Part Later the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage disease or condition Medical resulting in death) Due to (or as a conse ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examir and -transit Hospit I or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the bunal Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certific completed filler in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Pranticion To the best of my knowledge death occurred at the time, date and place and out to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) woweekShi 00055325

State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

925 Bishop Walsh Rd Cumberland MD21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

WONSOCK SHIN MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,15,17,17&19a&b PER ANA BD G922 12/19/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1816 11 SAMUE 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 055 HOSPITAT MONTGOMERU NER SPR NIG 8. Date of Birth (Month, Day, Year) Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Hours Min Missouri 1016-19-0425 Director 1 🗆 M 2 🗹 F or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No UBR SPRING JTGOMERY 10g. Citizen of What Country? 23a Funeral 9 20 NEW HAMPSHIRE items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. or 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Completed 3 Widowed 4 Divorced UNIX Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) UNK NOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Artella Tubbs John Samuels 19] 55 in Marin: Gross N. Street: RoChambres town, State MD C47/111 19a. Infgert Vansanitiens (1) brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ♥ Other (Specify) in state Signature of Funeral Service 28 Nate Adrato Myllib Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RENIAI DISEASE STAGE disease or condition resulting in death) END Medical Due to (or as a consequence of) Examiner ABETE IPIL Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on. HYPERTENSION burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
Property of the attending physicials be a signed by the attending physicial Box 68760 as the t IF FEMALE: or use 23c. If yes, outcome of pregnancy
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:00 PMM November 2011 Medical <u> John Edward Slebzak</u> 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Linthicum <u>308 Music Lane</u> 6. Sex 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours 1 XM 2 □ F **Director** 213-12-6977 Feb 17, 1921 New York 90 Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Linthicum MD Anne Arundel 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be Funeral 21090 USA 308 Music Lane death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ŏ þ 1 Never Married 2 X Married X Yes Yes. Giv Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. and ant. If then 27 is marked other than "natural", or ant. If then 27 is marked other than "hatural", or ury or other traumatic event, the Medical Examin 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: white 3 Widowed 4 Divorced 42-46 Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 8 n mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Michael Slebzak Hilda Nygard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Slebzak/spouse 308 Music Lane Linthicum, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify) ature of Euneral Service Rona State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, x, or heart failure. List only one cause on _ach line. Approximate Interval Between Onset and Death Immediate Cause (Fi disease or condition Cause (Final CHFPhysician Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

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4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

State Registrar

Medical

29a. Certifier (Check

only one) 29b. Signature and title of certifie

3 🗆

19

ed cause of death (Item 23a) (Type, Print)

807 LAHD MARK DRIVE SHITE 127 GHEN BYRNIE DomiHICK. 31. Date filed (Month, Day, Year,

🗙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month. Dav. Year)

261

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name First, Middle, Last 2. Date of Death 3. Time of Death Physician/ 90 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if n institution Taive street end number) **Examiner** ano bir 0 20 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number If Under 6. Sex 7. Age (In yrs. last birthday) Funeral Days Month Day, Months Hours Min 1 MM 2 □ F amaica Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits aţ 10a, State 10b. County within 72 hours after death with the Maryland Director Examiner must be notified STOW! 1 Yes 2 No anda 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a Funeral amail Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubap Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced "natural" lac Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary econday (0-12) College (1-4 or 5+) Be other traumatic event, should be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, Inform t's Name/Relationship (Type, Page 1 and 2 12118 20b. Place of Disposition (Name of cemetery, cremator) or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of h 1 Burial 2 Cremation 3 Removal from State any injury or 302011 4 ☐ Donation 5 ☐ Other (Specify) ar Services 21. Signature of Funeral Service Licens 22. Name and Address of Facility Tanda Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) a 🗌 Unknown 9 Unknown P.O. by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably Records, 4 Unknown 1 ☐ Yes 2 ☐ No Completed been signatures to the second 24b. Were autopsy findings available 24a. Was an nis certificate has b I director, page 2 st prior to completion of cause of death? autopsy performed After this certificate 1 Yes 2 No 1 Yes 2 N Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: A Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year,

State Registrar 31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Iter) 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40480 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 Month 06 Day 201 Year Annie J. Taybron 11:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Rehab Center
5. Social Security Number 6. Sex 7. Age / Fort Washington <u>Prince</u> George's 8. Date of Birth Month, Day, July 19 **Funeral** 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 □ M 2 √ F Months Days Hours Min Year, **Director** 282-34-5453 73 1938 MS Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director 1 Yes 2X No Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 11400 Fort Saratoga Court 20744 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Examiner Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No "natural" Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Me ical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Schould be filed within 72 hand Mental Hygiene.
7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Program Analyst Dept of Defense other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Curtis Carter Annie Dawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD²⁰⁷⁴⁴ permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once, Janatus W. Taybron, Jr.-Husband 11400 Fort Saratoga Court Fort Washington, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 2/22/2011 Arlington, VA <u>Arlington National</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland, MD 20746 Suitland Road 23a. Part 1. Enter the disease, or complications that sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physician at the burial-Physician/Medical Box 68760 attending p IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဂ္ 2 1100 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Division work? 2 🗆 No ☐ Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Mirse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifi Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 Old BRANCH Ave 101

Registrar DHMH 17 Rev 7/2009

State

of Vital

aistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Walter E. Warner December 2011 7:30pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Sykesville Examiner 4c. Coupty of Death Carroll Fairhaven 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov 18 1 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 ₹ M 2 □ F 91 Director 183-18-5210 Yrs. Ĭ920 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21784 7200 Third Ave. Apt. A-210 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 2 No WWII 1 Never Married 2 XMarried 1 Y Yes If Yes, Give Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🎇 No Specify: 3 - Widowed 4 - Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Air Force Col. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (*First, Middle, Maiden Surname*) Marie Drawbaugh ဂ္ Charles A. Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave., A-210, Sykesville, MD 21784 Mrs. Helen Warner (spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State All County Cremation 12-20-11 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nhu disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Tyes 2 No. 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director; A completed filled in by the fi Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title

DHMH 17 Rev 7/2009

State Registrar 1645 Libery

Wersburg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lucille Marie Wyatt 6:52p December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Finksburg 4520 Sykesville Road Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 G Days Hours (Month, Day, 92 215-22-8613 90 Director May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martal Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." The matural of the market of the market of the matural of the market of the m 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Carrol1 Finksburg 1 🗆 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4520 Sykesville Road 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ 1 ☐ Yes 2 X No Specify: white Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Magdalene Langley Rudolph Jameson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 289 Blackhaw Trail, Westminster, MD 21158 Herman F. Wyatt Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-23-11 Evergreen Memorial Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Parge Harget oferbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FHAPERSO INVLINOLIN disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence oi). or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital le B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 🗌 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident illed in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of ce

State Registrar

DHMH 17 Rev 7/2009

ause of death (Item 23a) (Type, Print)

1386

Shepter CENP

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Ward Physician/ 1225 AM Dallyl De 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Clinton Prince Georges Southern Maryland Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 577-06-8827 **Director** 55 1 🛛 M 2 🗌 F 1966 DC Jan 21, ital Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Prince Georges Fort Washington 10e. Street and Number 10g. Citizen of What Country? Funeral USA 7236 Lanham Lane 20744 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc 1 X Never Married 2 Married 2 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the Mail Clerk Private yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paulette Johnson William Ward other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Fort Washington, MD 20744 Paulette Ward - Mother 7236 Lanham Ln. Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Harmony Memorial Park 12-20-2011 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility
Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myo Conderd disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner カルノーナルら (codopo monas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform performed? Yes 2 No **eral Director;** After this certificate It filled in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mannerof Death 28a. Date of injury (Month, Day, Year) 28c, Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director, I

completely filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c License numbe 29d. Date signed (Month, Day, Year) DOCES 7-07 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 121119 750 3 SUCTAHS

State

Registrar

31. Date filed (Month, Day, Year)

9

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 15^{Day} Physician/ 12Month 201[°]Î MARY WOOD 9:15 C . AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice Tate House Anne Arundel Linthicum Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🛛 F Months Days Hours Min Year! 212-07-4936 91 1920 Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29 Thomas Rd. 21060 United States Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Even A. Fisher Ethel May Posey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Thomas Rd., Glen Burnie, Maryland 21060 Ethel Young / Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Denation 5 Other (Specify) Glen Haven Mem. Pk. 2011 Glen Burnie, Maryland ame and Address of Facility kley-Ruddick Funeral Home, P.A. Crain Hwy., S.E., Glen Burnie, 21. Signature of Queral Serv MD 21061 3 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician) disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): -transit requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last ng physician al as the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse (23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes No
9 Unknown Month Day Year Pregnant at time of death the 9 | Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autops page 2 2 No 1 Yes 2 1 \sum Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? HOSPICE 2 No Hospital Other: 1 🗌 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of De th 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Natural Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Hospital 24 hours Medical To the Hosp within 24 hou To the Funel completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 7/2009

State

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19201

29b. Signature and title of certifier

empleted cause of death (Item 23a)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last)
Marie E. Wells 3. Time of Death 2. Date of Death Month **Physician** 1:33 am Lecenber 2011 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and nu Examiner Hoer orien az 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 06/08/1916 Birthplace (State or Foreign Country) **Funeral** Hours Min. Days 1 □ M 2 K F MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Exartive runt for rolling at 1 □Yes Ž □ No Director MD Harford Abingdon 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 306 Millwright Circle 21009 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2x No If Yes, Give Year or Dates: Specify: Specify: White p Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Me ntal Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event the page." Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Smith Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Millwright Circle Abingdon, MD 21009 19a. Informant's Name/Relationship (Type. Print) Mary Ellen Novak 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial ☐ Cremation 3 ☐ Removal from State Gardens of Faith 12/19/2011 Rosedale, MD 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 610 W. MacPhail Rd. Bel Air, MD 21014 Inc. 21. Signatur / Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA ENDSTAGE * /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed P.O. Box 68760, Due to (or as a consequence of): physician a s the burial-1 Completed by Physician/Medical attending ph for use as th IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) signed by the a 1 □ Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 D 1 ☐ Yes 1 ☐ Yes : After this certification of the thick of t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

SURESH DHAW JAW.

31. Date filed (Month, Day,

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Marie

HAURE DEGRACE

6225 UNION

32. Registrar's Signature

11-09	317	
David	W.	Wells

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/ ical Examiner 1. Decedent's Name (First, Middle, Last) David W. Wells 4a. Facility Name (if not institution, give street and number) 1. Decedent's Name (if not institution, give street and number) 1. Decedent's Name (if not institution, give street and number) 1. Decedent's Name (if not institution, give street and number) 1. City, Town, or Location of Death 1. City, Town, or Location of Death 1. County of Death 1.	id W. Wells		State of Maryland / Department 1- For State Registrar Certificate		lygiene 2011 4048						
44 Family Name of not including. per sizes and number) 10 Commandow 10			Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death						
All 3 - 04 - 5.5.9.4 Table Tab			4a. Facility Name (if not institution, give street and number)	** '	h 4c. County of Death						
The State of Number of Deposition of Deposit			113 04 5504	Months Days Hours Mir	Foreign						
The content of the	E		10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits 1 Yes 2 No						
Secretary Secr	he Marylan or 28a-f si	Directo	10e. Street and Number	·							
Section Sect		Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) White, etc. White						
Section Sect	vithin 72 hours ene, er than "naturi Medical Exami		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 + Lav	g most of working life. DO NOT use ret	ired)						
Second S	uld be filed w Mental Hygie marked othe	Be	William Walker Wells Sr.	Franc	es Joan Welby Wells						
22 Name and Address of Facility Simplicity Crem & Fun Serve ThomasAllenPA 7090 Ridge Rd Hanover MD	I and 2 should filter 27 is er traumation		Jane Wells Wife 114 20a. Method of Disposition 20b. Place of Dis	174 Brundidge T	Perr Germantown MD 20876 Date 20c. Location - City or Town, State						
Thomas Allen PA 7090 Ridge Rd Hanover MD Robbert State (and state and the death). Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Fart List net bedsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Fart List net bedsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Fart List net bedsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Fart List net bedsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Fart List net bedsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Fart List net bedsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Fart List net bedsease, or complications that cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Fart List net bedsease, or complication as caused the death of Double to Cardiac the Cause of Cardia for the past 12 months? 25a Fart List net bedsease, or complication as caused the line of Cardia for the past 12 months? 25a Fart List net bedsease, or complication are death of Line of Cardia for the past 12 months? 25a Fart List net bedsease, or complication are death of Line of Cardia for the past 12 months? 25a Fart List net be	mit. Pages partment of portant: I ury or oth		4 Donation 5 Other Specify:								
The failure List only one cause on each line. Failure List only one cause on each line. Between Onset and Death Due to (or as a consequence of):		4	Thoms HU	<u> ThomasAllenPA 7</u>	090 Ridge Rd Hanover MD						
Section Company Comp	ed		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Part II. Other significant Part II. Other signific	sici be										
29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) December 11, 2011	death certifica ne attending pl	ysician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5								
29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) December 11, 2011	res that the signed by the be detached	ā	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.							
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) December 11, 2011	The law requi	Complete			autopsy prior to completion of cause of death?						
29b. Signature and title of certifier O.C.M.E. 29c. License number O.C.M.E. December 11, 2011	Physician: er this certif ral director,	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 ✓ Other: Scene								
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) December 11, 2011	Attending er death. rector: After the true functions of the functions of t	ication:									
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) December 11, 2011	Hospital or 24 hours aft Fuoeral Di tely filled in		Suicide Could not be determined (Specify) Found: Re	sidence	or Town, State) 11474 Brundidge Terrace Germantown, MD.						
29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Year) December 11, 2011	To the within To the comple	edic	one) 2 Medical Examiner:On the basis of examination and/or investigand manner stated.								
		Σ	29b. Signature and title of certifier								
	ϕ			ore Street, Baltimore, MD 21	223						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 40487 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Merritt Earl Williams December Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City Town, or Location of Death **Examiner** 1050 MOSE 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign last birthday) **Funeral** Hours Country) **Director** 217-26-2931 1 🛣 M 2 🗆 F 182 2/07/1929 PΑ Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Harford Fallston 1 Yes 2XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21047 USA 2137 Buell Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Banking Maintenance Be UNKNOWN 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 2 Virginia John Lee Williams Jilliams, 19a. Informant's Name/Relationship *(Type, Print)* Sherry Willliams—Daughter—in—law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5126 Windermere Circle Baltimore, MD 21237 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD 12/20/2011 4 Donation 5 Other (Specify) 22. Name and Address of FacilitySchimunek Funeral Home Inc. 21. Signature of Funeral Service Licens Te 9705 Belair Rd. Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Due to jor as a conditioned of artery Sequentially list conditions Examiner cause. Enter Underlying burlal-transi Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 : autopsy performe death?
1 Yes 2 No Yes 2 certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Natural injury 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practitioner: To the best of my knowledge, death occurred at the time, date, and due to the name as a tated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO071836 December, 16, 2011 Azher Merchant MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Baltimore MO. 21237 AZher 9000 Merchant 31. Date filed (Month, Day, Year) 32. Pegistrar's Signatu State DEC 1 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 40488 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ROBERT K. WELLINGTON 12 2011 3:02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2852 GARRISON AVENUE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth —23—1925 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. Director 214-20-9364 27 1925 86 Usual Residence of Deceden 28a-f shov 10a. State 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 XYes 2 No MD BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 2852 GARRISON AVENUE 21215 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nater any injury or other than". Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No Specify: WWII Specify: BLACK 3 Widowed 4 N Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HEATER BETH STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH WELLINGTON MARY KING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2852 GARRISON AVE., BALTO., MD 21215 STANLEY WELLINGTON/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST CEM 12/22/11 OWINGS MILLS, MD 21. Signature of Futural Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC an BALTO., 1701 LAURENS ST., MD 21217 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Menmaloma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Gause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) raples 84. Ste 4105, Baltimore 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:47 AM Vonzella Whitney 2011 ecombo Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Agres Hospitel Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Months Hours Min Maryland Director 219-26-8046 75 Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Y⊆ Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4215 Eldone Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. β 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatin aware. 1 Yes 2X No Specify: Completed Specify: Black 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Factory Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Charles Savage Lottie Houston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Whitney 3204 Wheaton Way #K, Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 12/22/2011 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lice (see 22. Name and Address of Facility Latimore Funeral Services. PA umore 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner eau Viras Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (o as a consequence of) Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by neumona 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has lirector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) a.D HICENCH lint 2406 December 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HIGING TINT, 900 Codon Avenue Balti more MD 21229

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

9

Busto

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 6. 201T 9:50 PM M John T. Webner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Marys Charlotte Hall Charlotte Hall Veterans Home 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Hours (Month, Day, Year) ar 5, 1924 Washington DC 1 🕅 M 2 □ F Director 579-20-6803 Mar Usual Residence of Deceden ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director 1 ☐ Yes 2√ No Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1300 Stratwood Avenue 20745 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1. Marital Status Armed Forces?

1 Xyes 2 No
If Yes, Give Black, White, etc. Hygiene. 1 Never Married 2 X Married þ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 43-44 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 0 truck driver transportation Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည H.T. Webner Gertrude Hastings 1 and 2 should be Health and Meritem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lucie Webner/spouse 1300 Stratwood Avenue Oxon Hill. MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Toursel Sarv State Anatomy Board 655 W. Baltimore Street rector en Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No ed by the a detached a Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be def ð 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? • Hospital or Attending Physician: The law r 24 hours after death. • Funeral Director: After this certificate has b performe 1 🗆 Yes 2 🗆 No 13ea3e 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Place of Death (Pheck only one) Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 **1** No 1 🗌 Yes Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifier

State Registrar 30. Name and address of person who con

32.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

attelfall MD 20622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Зŏ, 2011 4:30 PMM November Medical Peter B. Zieger 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury 425 Elberta Avenue 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours (Month, Day, Year) 214-42-7634 **Director** 1 🗓 M 2 □ F Feb 9, 1945 Maryland 66 Usual Residence of Dece show 10d. Inside City Limits must be notified at 10a. State 10c. City, Town or Location Director 28a-f 1 Yes 2X No Wicomico Salisbury 10e. Street and Number ö 10f, Zip Code 10g. Citizen of What Country? Funeral 23a USA 21801 425 Elberta Avenue items ? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status event, the Medical Examiner Armed Forces?

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white "natural", 3 Divorced 4 Divorced Completed **'**63**-**70 unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 computer programmer permit. Page 1 and 2 should be filed win Department of Health and Mental Hygie Important: If Item 27 is marked other any injury or other traumatic access 2. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Peyton Brinckloe William Charles Zieger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21801 Kathryn Zieger/spouse 425 Elberta Avenue Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final Ph_sician/ disease or condition ancreati omio Medical resulting in death) Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician sthe burial Physician/Medical P.O. Box 68760 use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the Hospital or Attending Physician; The law requires that the þ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death.

e Funeral Director: A sletely filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely. (Check within 2.

To the F

complet Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Vernon Rd

(Item 23a) (Type, Print)

on who completed cause of de

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ 04:18 AM ALEXANDER 11 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 8. Date of Birth Hours 1 🗆 M 2 🔀 F **Director** 291-50-5370 62 8/25/1949 Ohio 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MdCharles Waldorf o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20601 2509 Breakwater Court USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ori þ 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify. should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Eonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry Coordinator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hamlet Betty George T. Alexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2509 Breakwater Ct.,Waldorf, Md. Delores Beard/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Donation 5 Other (Specify) Resurrection Cem. 12/2/2011 Clinton.Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility $Bluford\ Funeral\ Service$ Chrylle 19 Blu 2019 MLK Ave., SE, Wash., DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC Physician/ SHOUL disease or condition Medical resulting in death) Examiner 3 DAYS ENCEPHATOPATHY HEPATIC Sequentially list conditions, Examiner If any, leading to inhirediate cause. Enter Underlying DAYS and i-transit C. DIFFICILE or Attending Physician: The law requires that the death certificate be executed COLITIS Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical 3 MONTHS SPD HEMODIALYSIS Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a lld be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BILLARY Circhosis 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown been signature 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page death? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🔀 No 욘 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After th 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D72931 11 2011 Dr. KADIYALA 22

State Registrar Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Dale Brooks Nov 30 Day 2011 Year 1208 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 X M 2 - F 10-16-1946 Michigan Director 219-48-4731 65 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Directo 1 Yes 2 X No Anne Arundel Tracy's Landing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6522 Clagett Avenue 20779 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2

No If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Hygiene. 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced Specify: Completed Year or Dates. 1969-73 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Coilege (1-4 or 5+) 1 and 2 should be filed with f Health and Mental Hygien item 27 is marked other th Computer Contracting <u>Project Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herman Emerson Brooks Juanita Murdock Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jinny L. Brooks, Spouse 6522 Clagett Avenue, Tracy's Landing, MD 20779 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/01/11 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pancrea disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter of denying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 E FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown the P.O. been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes Division of Vital funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 29b. Signature and title of certifier November 30, 2011 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Patel, MD 110 Hospital Rd. Prince Frederick Maryland 20678

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NFC - 2 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:50pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANDRIN INPATIENT CARE CENTER ANNE ARUNDEL HARWOOD Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months 1171871929 Director 82 NORTH CAROLINA 241-46-6499 Usual Residence of Decedent 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits notified 28a-f MD QUEEN ANNE'S STEVENSVILLE 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 2204 ROMANCOKE ROAD 21666 UNITED STATES Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 0 Black, White, etc should be filed within 72 hours after of and Mental Hygiene. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Completed Specify: 3 X Widowed 4 □ Divorced WHITE Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALES RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ BEN L. EDWARDS GENEVA HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh tment of Health a tant: If item 27 is SHEILA M. PERRY / DAUGHTER 754 HOLLY DRIVE, ANNAPOLIS, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE^{tto}CKEMATTON CENTER injury or 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 12/01/2011 STEVENSVILLE, MD FELLOWS. HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NURMONA disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy
 Other (specify) _____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? autopsy performed' 1 ☐ Yes 2 ☐ No of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \nearrow Other (Specify) M + N D C I N2 ENO 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) Division 5 Pending s after death.

I Director: Aff
d in by the fur 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Jame and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Regis AMEND#5perFH, 12/2/11; BMW, McCo 40496 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Brown 10:13 PM NON Inomas 201 Medical 4a. Facility Name (if not institution, give street and number)
8534 Paddock View 4b. City, Town, or Location of Death County of Death Examiner Montgomer If Under 24 Hrs. 8. Date of Birth Sa Social Security Numbeukn If Under 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Days Min ngland Director temavailable Usual Residence of Decedent 28a-f shov with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No Maryland 10e. Street and Number raithersbu 10f. Zip Code ō 10g. Citizen of What Country? items 23a Funeral united States 26883 View 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Examiner 1 Never Married 2 Married "natural", or <u>გ</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO Specify. Specify: Black Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Government contractor Government Be 17. Father's Name (First, Middle, Last) ပ Krown Mahle ting 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Kodne lorrance 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3- U Beltsville, MD 4 Donation 5 Other (Specify) resolvable Crematory 22. Name and Address of f Funeral Service Licensee nd Funeral Services w wasy, VC 20011 New wash 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ 800m disease or condition resulting in death) 120 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). attending physician and for use as the burial-tr that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: thin 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1
Natural 5 Pending injury Self inflicted Gun 1 ☐ Yes 2 🔀 No Unkm within 24 hours after death. To the Funeral Director: A Accident Investigation NOV 26 2011 completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rula Roundstreet and Number of Rula Roundstreet and Street and determined Home OO Theisburg 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 00428 NMO DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K856 V8 BRECHER MOOME 31. Date filed (Month, Day, Registrar's Signature State **DEC** 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40497 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Benjamin F. Brown IV 6:00 A M 2011 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4550 N. Park Avenue Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 457-36-9263 Days 1X M 2 - F Months Hours 06/24/1930 Director Texas Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD Montgomery Chevy Chase 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4550 N. Park Avenue 20815 United States hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married <u>6</u> Maryland 21215-0036 Specify: White Il Hygiene. If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Government and (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education 5+ Researcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F is marked or ဂ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Benjamin F. Brown III Mary Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Lovett / Wife 4550 N. Park Ave. Chevy Chase, MD 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🛚 Cremation 3 D Removal from State 11/30/2011 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Years organitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🖺 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed this certificate Yes 2 XN 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5X Residence 6 \square Other (Specify) 1 ☐ Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After 1 X Natural 5 Pending work 1 🗌 Yes 2 No Investigation Completed filled in by the Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my nowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 of certifier 29b. Signature and title 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

Registrar RFC 0.1 201

31. Date filed (Month, Day, Year)

dress of person who completed cause V. Young MD 4530

25992

of death (Item 23a) (Type, Print) Connecticut Ave. NW #104 Washington, DC 20008

11/29/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28^{Day} **Physician** Nov. 201 Par 7:50pm м William J. Barbour /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bradford Oaks Center Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) Days Hours 1 🔲 M 2□ F Director 577 44 1395 Sept 27, 1933 Washington DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Wedical Evanings must be routifed at 1 ☐ Yes 2 ☐ No Director Maryland | Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8500 Mike Shapiro Drive #319 20735 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∏Yes 2 ∏ No If Xes, Give Year or Dates: 1 ☐ Never Married 2 Married Korean Baltimore, Maryland 21215-0036 1 □Yes 2 🙀 No ģ Specify: Black. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) Printer Federal Government permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygid Important; If item 27 is marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rossie Lee Barbour ပ Willie Mae Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Armenthia Barbour (Wife) 8500 Mike Shapiro Drive #319, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-5-2011 Suitland, MD Lincoln Memorial Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signatury of Funeral Service Licenses m00257 Wand Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** USAN disease or condition resulting in death) /Medical to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. signed by the a 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 0 3 Probably 4 Unknown 1 □ Yes should Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy death? certificate I E NO 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 1□Yes 217/19 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

29b. Signature and tine of certifier

of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia Rosalee Bittinger Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS Regional Medical Center Cumberland Allegany Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Min Auq. 28, 1 □ M 2 X F ^(ear)1941 Maryland **Director** 215-56-8469 70 Usual Residence of Decedent 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett Grantsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2402 Frank Brenneman Rd. 21536 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 **X**No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 K No Specify: "natural", 3 Divorced Specify: White Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irvin Snyder Harriett Ohler and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Debra Bittinger/Daughter 21536 2402 Frank Brenneman Rd., Grantsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bittinger Cemetery Dec. 8, 2011 Bittinger, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Linensee terman P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition M925 hu2 do Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Tract Intection 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page performed' Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 뎯 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death. Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 \square Homicide 24 hours a Hospital Medical 29a. Certifier LEcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mustra 12.5.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

Christopher Vagnoni, 12500 Willowbrook Rd., Cumberland, MD 32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 28, 2011 **Physician** 10:30 PM Grace Marie Braskey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Grantsville Goodwill Mennonite Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Jan. 15, 1916 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F Maryland Director 217-10-4258 Jan. Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County "natural", or items 23a or 28a-f st ofcet Examination relified 1 ☑ Yes 2 ☐ No Director Garrett Grantsville the 10e. Street and Number 0f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21536 USA 144 B. Main St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify. 3 ☑ Widowed 4 ☐ Divorced White Completed if Health and Mental Hygiene.
item 27 Is marked other than "natur
other traumatic event, it is Medical." 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Co-Owner/Operator Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Smith John L. Carey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 52, Grantsville, MD 21536 John G. Braskey/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Grantsville Cemetery Dec. 2, 2011 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee reuman P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) multi **Physician** 54ews inturco /Medical Due to (or as a construence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a nonsequence of law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been signated by page 2 should by 1 ∨ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 □ Yes 2 **N**No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 00 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

NOV 3 0 2011

31. Date file (Month, Day, Year)

Margareta Kaiser

13079 garrett highway
32, Registrar's Signature

30. Name and addr as of person who completed cause of death (Item 23a) (Type, Print)

oakland, md 21550